SALISH BHO

UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

Salish Behavioral Health Organization
Level of Care
Condensed Version

Revised July 2017
Effective October 1, 2015

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Age Definitions

Child: A *child* is defined as a person birth to 12 (twelve) years of age.

Youth: A *youth* is defined as a person 13-17 years of age, requires youth consent.

- For persons eligible for the Medicaid program, the term *youth* extends to individuals that have not reached their 21 (twenty-first) birthday. NOTE: The new ACS defines youth as below age 21, and either the Adult or Child & Youth ACS criteria may be applied to individuals age 18-20.

Adult: An *adult* is generally defined as a person over the age of 18 (eighteen) years.

- For the purposes of residential services, an adult is always defined as a person 18 (eighteen) years or older.

Child & Youth Services

Child and Youth Services
Level 1 Outpatient Services

Service Description

- Brief Intervention is a solution focused, outcomes oriented cognitive and behavioral intervention intended to resolve situational disturbances that do not require long term treatment. Authorization benefit: 12 service hours within 6 months, *one time only authorization*.
- Low Intensity Treatment is provided to allow a child/ youth and family to continue in treatment to maintain their recovery progress. Functional problems identified in the ISP, include steps that demonstrate on-going treatment progress. This level may be used as a step down from a higher, more intense level of care and authorized for multiple episodes. Authorization benefit: 24 service hours for 12 months.

Routine Admission Criteria

- Individuals must meet the Washington State Access to Care Standards (ACS), and the requested service is determined medically necessary by MHP.

  EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria in addition to the ACS may be authorized for Level 2 services:

  1. Involved in one or more of the following systems in addition to mental health:
     - Children's Administration
     - Developmental Disabilities Administration
     - Juvenile Rehabilitation or Department of Corrections
  2. Diagnosed with Substance Abuse or Addiction
  3. Receiving Special Education Services
  4. Has a chronic and disabling medical condition
  5. As a Medicaid recipient, has previously been authorized for Level 1 services twice.

  In addition to the ACS, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following criteria:

  1. Present with psychotic symptoms
  2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
  3. Recently released from JRA or Juvenile Detention facility
  4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
  5. Under age of 6 years, inadequate caregiver
  6. Applied for Medicaid and enrollment decision is pending

Continuing Stay Criteria

- Medicaid individuals can only be re-authorized for Brief Level 1 services ONCE.
- Review and documented treatment progress, update ISP, and review / update the crisis prevention plan, as appropriate.
- Requested continued service is determined medically necessary by MHP, and must meet all of the following:
  1. Current ACS covered diagnosis.
  2. Current symptoms (from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued; and continued treatment is necessary to maintain gains to maintain community safety or to avoid hospitalization.
  3. Intervention is deemed necessary to improve or stabilize functioning (from the covered diagnosis).
  4. The individual is expected to benefit from the intervention(s).
  5. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).

Type of Services/Modalities

- Intake assessment, group treatment, brief intervention treatment services, individual and family services, medication management, medication monitoring, psychoeducation, and family/ peer supports.

Intensity of Service

- Brief intervention and/ or low intensity mental health services

Duration of Episode

- Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Low Intensity: Maximum of 24 individual service hours for 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA submits a PRAT (identifying the service level, determination of ACS requirements and medical necessity) to SBHO delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation and then provides an authorization determination within 14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests, when indicated.
- Written notification of authorized services is provided via mail.

Child and Youth Services
Level 2 Outpatient Services

Service Descriptions

Long Term Rehabilitation and Children's Intensive Services (CIS) are necessary to improve or maintain stability in the community. Intense level of acute outpatient treatment may include active outreach and home-based services necessary to prevent hospitalization, out of home placement, reinforce personal and community safety and/or decrease the use of other costly services. CIS is the most intensive outpatient authorization for children's services. Authorization benefit: More than 24 service hours up to 12 month authorization episode.

Wraparound with Intensive Services (WISe) is a range of Medicaid-funded service components that are individualized, intensive, coordinated, comprehensive, culturally relevant, and home and community based. WISe is for youth who are experiencing mental health symptoms that disrupt or interfere with their functioning in family, school or with peers. WISe services may be requested prior to intake by either the youth, family, or family representative. Youth eligible for WISe based services, if not enrolled in SBHO agency, will be referred for intake and to determine further medical necessity and access to care standards.

Routine Admission Criteria

Individuals must meet the Washington State Access to Care Standards (ACS), and the requested service is determined medically necessary by MHP.

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria in addition to the ACS may be authorized for EPSDT services:

1. Involved in one or more of the following systems, in addition to mental health:
    - Children's Administration
    - Developmental Disabilities Administration
    - Juvenile Rehabilitation or Department of Corrections
2. Diagnosed with Substance Abuse or Addiction
3. Receiving Special Education Services
4. Has a chronic and disabling medical condition
5. As a Medicaid recipient, has previously been authorized for Level 1 services twice.

CIS. Any Medicaid recipient from 5-17 years of age who meets <u>any one</u> of the following criteria may be authorized for CIS services:

1. Involved in two or more of the following systems, in addition to mental health
    - Children's Administration
    - Developmental Disabilities Administration
    - Juvenile Rehabilitation or Department of Corrections
    - Receiving Special Education services
    - Involved with substance abuse or chemical dependency services
2. Has been hospitalized for psychiatric care within the previous 12 months
3. Three or more crisis contacts in the previous 6 months (to be counted by day)
4. Has received inpatient treatment for substance abuse within the previous 12 months

** In addition to the ACS, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following criteria:

1. Present with psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from JRA or Juvenile Detention facility.
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Under age of 6 years, inadequate caregiver
6. Applied for Medicaid and enrollment decision is pending

- <u>Safety/ Risk Assessment</u>. In addition to the above criteria, one of the following qualifying risk factors must apply for an individual:

1. Current severity of symptoms makes the individual at risk for hospitalization, if services are not provided at this level
2. Child/ youth's placement is at significant risk
3. More than 3 contacts with the provider crisis team in the previous month
4. Psychiatric hospitalization in the previous three months
5. Current suicidal or homicidal ideation, or history of an attempt
6. Is EPSDT program eligible

***Additionally, WISe services are determined by a CANS screen documenting eligibly for WISe services, performed by someone certified in performing the CANS screens and assessments, either prior to authorization for services or in conjunction with the intake assessment. Consideration for referral begins with youth who are Medicaid eligible, under age 21 and who have complex behavioral health needs. Other indicators to consider for a WISe referral may include, but are not limited to:

1. Youth with involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, developmental disabilities, special education, substance use disorder treatment).
2. Youth for whom more restrictive services have been requested, such as psychiatric hospitalizations, residential

placement or foster care placement, due to mental/behavioral health challenges.

3. Youth at risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
4. Youth who have been significantly impacted by childhood or adolescent trauma.
5. Youth prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
6. Youth with a history of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
7. Youth exhibiting risk factors such as suicidal ideation, danger to self or others, behaviors due to mental/behavioral health challenges.
8. Youth whose family requests support in meeting the youth's mental/behavioral health challenges.

Continuing Stay Criteria

- Review and document treatment progress, update ISP, and review/update the crisis prevention plan, as appropriate.
- For WISe services, documented Cross System Care Plans (CSCP) with updated WISe screens every 90 days is annotated in the electronic health record via Child and Family Team (CFT) notes validating continued services with WISe.
- Medicaid individuals: EPSDT and CIS program requirements are met (listed above in admission) as determined medically necessary by MHP
- In addition to the above criteria, all of the following must apply to an individual, as determined by MHP:
    1. Current ACS covered diagnosis.
    2. Current symptoms (from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued; and continued treatment is necessary to maintain gains to maintain community safety or to avoid hospitalization.
    3. Intervention is deemed necessary to improve or stabilize functioning (from the covered diagnosis).
    4. The individual is expected to benefit from the intervention(s).
    5. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).

Non-Medicaid individuals: Sufficient resources and continue to meet ONE of the ** additional criteria as determined medically necessary.

Type of Services/ Modalities/ Intensity of Service

- Includes all allowable outpatient services under the state plan; full scope of outpatient treatment modalities.
- EPSDT and CIS can require establishing a formalized Individual Service Team and further development of a Cross-System Treatment Plan.

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists. CMHA submits a PRAT to SBHO delegated ASO within 14 days from when the intake was initiated.
- Excluding WISe services, the ASO reviews PRAT and supporting documentation, then provides an authorization determination within *14 calendar days from the date of the request for service. ASO reviews and authorizes extension requests.* Written notification of authorized services is provided via mail.

Child and Youth Services
Level 1 & 2 Services
Expedited Reviews: Admission & Continuing Stay for Medicaid

MEDICAID ONLY (42 CFR 438.210)

This Level of Care applies to expedited authorization reviews for admission and continuing stay for Level 1 and 2 outpatient services.

Service Description

- For cases in which a network provider (CMHA) indicates that the following the standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the CMHA MHP must make an expedited authorization request for services, indicating urgent or emergent review status, and provide an authorization request as expeditiously as the individual's health condition requires.
- Crisis services can be provided while the expedited authorization request is pending.

Expedited Admission Criteria

- Individuals with Medicaid coverage, only.
- The standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function
- For admission authorization determination: Must meet Access to Care Standards (ACS) for Admission into Level 1 or 2 services criteria (medical necessity criteria, functional impairment, and diagnosis)
- For continuing stay authorization determination: Must meet continuing stay criteria, as defined by the requested level.
- Requested service is determined medically necessary by MHP

Type of Services/Modalities

- Level 1: Intake assessment, group treatment, brief intervention treatment services, individual and family services, medication management, medication monitoring, psychoeducation, family/ peer supports.
- Level 2: Includes all allowable outpatient services under the state plan, including a screening for WISe eligibility. The full scope of outpatient treatment modalities and level of intensity for each modality may be provided based on clinical assessment, medical necessity and individual needs.
    - EPSDT referred Level 2 services for Medicaid youth can require establishing a formalized Individual Service Team for each child/ youth to further develop a cross system Individual Treatment plan (refer to Child/ Youth LOC for criteria and requirements)

Intensity of Service

- Level 1: Brief intervention and low intensity mental health services
- Level 2: Service intensity is individualized, based on *continued* assessment of need and adjustments are reflected in the ISP.

Duration of Episode

- Level 1 Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Level 1 Low Intensity: Maximum of 24 individual service hours within 12 months
- Level 2 Long Term Rehabilitation: Minimum of 24 individuals service hours in 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts an intake evaluation by an MHP that establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA telephonically provides or forwards a completed PRAT request with the urgency category flagged to the SBHO ASO. All telephonic information is followed-up with the required documentation.
- ASO immediately reviews the PRAT information, diagnosis information and any additional clinical documentation to support the request, prior to making a service determination, within 3 days from the request.
- ASO provides an authorization determination within 3 working days from the date of request for mental health services. The CMHA may extend the 3 day time period up to 14 calendar days if the individual applying for services requests an extension, or if the provider justifies a need for additional information and how the extension is in the individual's interest.
- Written notification of approved or denied services is provided via mail.

Child and Youth Services
Level 1 & 2 Services
Inactivation & Reactivation of Services

Service Description

- Clinical inactivation refers to an individual who has left services within an authorized benefit period. Clinical Inactivations can occur at any point throughout an authorized episode of treatment. *When there has been no direct services provided for authorized episodes over 90 days, the SBHO strongly recommends supervisory review and consideration for administrative closure.*
- Administrative inactivation refers to the expiration of an authorized benefit period (6 or 12 months). In rare occurrences, an administrative inactivation is requested when an individual moves out of the catchment area (including enters the prison system) or dies within an authorized benefit period.
- Reactivation refers to re-opening a previously clinically inactivated case, within the initial authorized benefit period.

Inactivation Scenarios

- Applies to Medicaid and Non-Medicaid individuals.
- Clinical inactivations may occur when any of the following apply:
  1. The client met their expected treatment goals/outcomes
  2. The client is over the age of 13 years and requests inactivation of treatment
  3. The client is not participating in treatment, has not responded to engagement efforts, and imminent risk issues are not present
  4. The client's whereabouts are unknown, and three attempts to contact them (by two different means) have been unsuccessful
  5. The client's treatment needs can be met through other services available within their support system; care is being/ has been transitioned to another entity
- Administrative inactivations may occur when any of the following apply:
  1. The client does not meet continuing stay criteria and the benefit period expires
  2. The client has moved out of the SBHO
  3. The client is deceased

Reactivation Criteria

- Applies to Medicaid and Non-Medicaid individuals. The request for reactivation is made by a MHP or the primary clinician, under the supervision of a MHP. Non-Medicaid individuals may only be re-activated if there are sufficient resources to support the re-activation service plan.
- Reactivation summary is required to document current information. For WISe services, a new CANS screening must be completed and entered into BHAS for eligibility determination. No additional authorization is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Authorization Protocols

- Inactivations
  - CMHA records the clinical inactivation and documentation summary in the Profiler clinical record.
  - The ASO generates a monthly report to identify individuals with pending administrative inactivations. After 10 days, if the Medicaid individual does not contact the ASO or CMHA requesting on-going services the inactivation is processed/ authorized.
- Reactivations
  - Reactivation documentation is present in the clinical record and re-activation status is entered into Profiler. No additional authorization through the ASO is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Child and Youth Services
Community Hospital Inpatient Services - Voluntary & Involuntary

Service Description

- Inpatient psychiatric services at community hospitals include evaluation, stabilization and treatment and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- The SBHO network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalization requests must be made by a MHP in consultation with, or by a child mental health specialists.

Voluntary Admission Criteria

Voluntary inpatient admissions must meet all of the following baseline criteria (includes Parent-Initiated Voluntary hospitalizations):

1. The existence of a DSM-5 disorder.
2. Evidence that admission is medically necessary.
3. The child/youth poses an actual or imminent danger to self, others or property due to a mental disorder, or
   The child/youth requires brief stabilization and assessment to rule out danger to self and/or others, or
   The child/youth is experiencing significant deterioration in age appropriate behavior including family, school, and social functioning and an alternative care setting would be unable to provide sufficiently intensive services to diagnose and treat the mental disorder.
4. There is a verified failure of treatment at a lesser level of care, or
   A crisis team/ DMHP determines that due to the severity of symptoms, intensity of treatment or lack of supports services cannot be provided at a lesser level of care.
5. Medical evaluation determines that the current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When a child/youth *may exceed* the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The inpatient facility is responsible for requesting an extension at least 24 hours prior to the expiration date. The inpatient facility must contact the designated network CMHA to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. The continuing stay/ extension request is case specific and there is no range for authorization.

- At least one of the following criteria must be present inpatient extension authorization (includes Parent-Initiated voluntary hospitalizations):
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The child/youth continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The child/youth demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The child's/youth's level of functioning has regressed since admit
  5. The child/youth continues to need stabilization to reach baseline functioning and further improvement in condition is expected.

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met or unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat and the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, a child/youth can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, a child/ youth must meet continued stay criteria to be authorized.
- *A new certification number must be requested* and is automatically issued to differentiate between inpatient facilities and legal status changes.

Retro-authorizations

A community hospital may request retro-authorization reviews. For out of state retro-authorization requests, the request must be must be made within three months of discharge.

1. The retro-authorization determination can take up to an additional 30 days.
2. Individual currently admitted to an inpatient facility, CommCare may provide a verbal review and retro-authorization.
3. Individual discharged from inpatient facility, CommCare requires hospital documentation for comprehensive review and determination.

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) for 20 days.
- For voluntary hospitalizations, the standard benefit period for admission and extension requests is determined and requested by the CMHA crisis team (standard range is 1 to 3 days).

Authorization Protocol

- The ASO collects the necessary information for Provider 1 Prior Authorization from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation. CommCare will notify DBHR of all Parent-Initiated Voluntary stays.
- ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day.

Child and Youth Services

Youth Inpatient Unit (Network E&T) - Voluntary & Involuntary

Service Description

- Inpatient hospitalization services for children and youth at Kitsap Mental Health Services (KMHS) Youth Inpatient Unit (YIU) include evaluation, stabilization and treatment and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- The SBHO network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalization requests must be made by a MHP in consultation with, or by a child mental health specialists.

Voluntary Admission Criteria- up to a standard 20 day initial authorization. Voluntary inpatient admissions must meet all of the following baseline criteria (includes Parent-Initiated Voluntary hospitalizations):

1. The existence of a DSM-5 disorder.
2. Evidence that admission is medically necessary.
3. The child/youth poses an actual or imminent danger to self, others or property due to a mental disorder, or
   The child/youth requires brief stabilization and assessment to rule out danger to self and/or others, or
   The child/youth is experiencing significant deterioration in age appropriate behavior including family, school, and social functioning and an alternative care setting would be unable to provide sufficiently intensive services to diagnose and treat the mental disorder.
4. There is a verified failure of treatment at a lesser level of care, or a crisis team/ DMHP determines that due to the severity of symptoms, intensity of treatment or lack of supports services cannot be provided at a lesser level of care.
5. Medical evaluation determines that the current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests- up to 10 additional days, per request

When a child/youth *may exceed* the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The E&T must contact the network CMHA that initiated the admission to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization. *Each extension request must be reviewed by the SBHO. Upon SBHO review, the request is forwarded from the SBHO to CommCare for authorization.*

- At least one of the following criteria must be present for continuing stay authorization (includes Parent-Initiated Voluntary hospitalizations):
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The child/youth continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The child/youth demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The child's/youth's level of functioning has regressed since admit
  5. The child/youth continues to need stabilization to reach baseline functioning and further improvement in condition is expected.
- Once an individual is admitted to the E&T, the CMHA must contact the E&T to begin coordinating care within one business day.

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met or unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat and the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, a child/youth can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, a child/ youth must meet continued stay criteria to be authorized
- *A new certification number must be requested* and is automatically issued to differentiate between inpatient facilities and legal status changes.

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care.

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) for 20 days.
- For voluntary hospitalizations, the benefit period for admission is up to 20 days. Extension requests (up to 10 days) are requested by the CMHA, reviewed by the SBHO, and authorized by CommCare.
- Continuing stay and extension requests range of days authorized are on a case by case basis.

Authorization Protocol

- Only network CMHA can request authorization for E&T inpatient services, all other parties must facilitate their request through the CMHA.
- The ASO collects the necessary information for an inpatient certification from Profiler or verbally- identifying the requested inpatient authorization. A*ll extension requests must be submitted to the SBHO for review 3 calendar days prior to the expiration. Upon SBHO review, the request is forwarded to CommCare for authorization*. CommCare will notify DBHR of all Parent-Initiated Voluntary stays.
- The ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day. SBHO conducts 100% review of all NOAs and tracks appeals.

Child and Youth Services
Children's Long Term Inpatient (CLIP) Services

Service Description
CLIP services are a blended residential program that includes therapeutic, medical, and educational modalities for severely emotional disturbed children and youth. CLIP is considered the most restrictive setting. The average length of stay is 6 months. This criteria is for *voluntary* CLIP services.

Routine Admission Criteria
- Applicants must have a severe psychiatric impairment which warrants the intensity and restrictions of the treatment provided in a CLIP Program with verified failure (unable to stabilize) of treatment at a lesser level of care determined medically necessary.
- Per CLIP Administration policy, an individual will be considered to have an impairment if a severe emotional disturbance, corroborated by a clear psychiatric diagnosis, is demonstrated, with one or more of the following behaviors exhibited:
    1. Symptoms explicitly associated with marked, severe and/or chronic thought disorders, as defined in the DSM-5, such as bizarreness, delusions, hallucinations, disturbed thought processes (e.g., loosened associations, illogical thinking, poverty of content of speech), blunt, flat or inappropriate affect, or grossly disorganized behavior
    2. Symptoms explicitly associated with a marked, severe or chronic affective disorders, as defined in the DSM-5, including mania, depression, vegetative signs, suicide attempts or self -destructive behaviors.
    3. Chronic or grossly maladaptive behaviors due to a diagnosed severe psychiatric impairment. The presence of such symptoms should be clearly identified as resulting from a mental disorder and not be solely attributable to other factors.
- Medical evaluation determines that the child's/ youth's current medical needs do not exceed the level of care available in the CLIP setting.
- Clear treatment goals and discharge planning recommendations including placement are provided to the CLIP program, prior to admission.
- Youth (13 years or older) are willing to agree to voluntary admission and to comply with treatment.
- Youth (13 years and older) whose mental state incapacity or developmental stage does not rule out a "good faith voluntary" admission by virtue of significant cognitive impairment that precludes making a reasoned decision. Determination of "Good Faith Voluntary" may include a review of previous voluntary hospitalizations and the recent pattern of outpatient treatment compliance.
- The local CLIP gatekeeping committee reviews all the material in accordance with these admission criteria, discusses alternative options to CLIP, and provides a determination for CLIP admission.
    1. If the application is approved, it is forwarded to the CLIP Admission for review and approval.
    2. If the application is denied by the community gatekeeping committee, a letter is provided with alternative treatment recommendations outlined.

Continuing Stay Criteria
- Per the CLIP policy, once a child/ youth has been approved for voluntary admission by the CLIP Certification Team and placed on the CLIP Waiting List, the designated child psychiatrist shall review the youth's continued need for admission every 30 days up until the time when they are admitted.

Discharge Considerations
- When the individual meets their treatment goals, no longer meets CLIP criteria for continued stay treatment, and a discharge date is identified:
    1. The CLIP treatment team members, including the community treatment team, shall plan for a smooth transition back to community services.
    2. The CLIP case manager is responsible for coordinating outpatient mental health services and will invite ancillary community-based formal systems to participate in the discharge planning, per established designated working agreements (e.g. DCFS and DDA).
    3. All youth discharging from CLIP treatment will be screened for WISe services prior to discharge, by a certified CANS screening and assessment staff member.
    4. If the child/ youth is planning to move to another BHO, the SBHO CLIP case manager coordinates with the local community mental health agency to liaison and transition care.

Type of Services/Modalities
- Blended residential program that includes therapeutic, medical, and educational modalities for SED children and youth.

Intensity of Service
- 24/7 long-term statewide residential program

Duration of Episode
- Upon admission to a CLIP facility, as determined by CLIP attending psychiatrist. Average LOS is 6 months.

Authorization Protocol
- Voluntary admission authorization occurs through a local gatekeeping panel review, and statewide CLIP Review. No additional authorization is required, upon admission.

Adult Services

Adult Services
Level 1 Outpatient Services

Service Description

- Brief Intervention is a solution focused, outcomes oriented cognitive and behavioral intervention intended to resolve situational disturbances that do not require long term treatment. Authorization benefit: 12 service hours within 6 months, *one time only authorization.*
- Low Intensity Treatment is provided to provide a person to begin or maintain their recovery progress. Functional problems identified at Intake are included in the ISP, which includes specific steps that demonstrate on-going treatment progress. May include beginning or ongoing care, maintenance or monitoring of current level of functioning, assistance with self-care, or life skill training. This level may be used as a step down from a higher, more intense level of care and authorized for multiple episodes. Authorization benefit: 24 service hours for 12 months.

Routine Admission Criteria

- Individuals must meet Access to Care Standards (ACS), and the requested service is determined medically necessary by MHP.

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria and ACS may be authorized for Level 2 services (reference Child/ Youth LOC for criteria and requirements):

In addition to the ACS, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison.
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Applied for Medicaid and enrollment decision is pending

Continuing Stay Criteria

- Continuing Stay criteria only apply for continuation of previously authorized services.
- Medicaid individuals can only be re-authorized for Brief Level 1 services ONCE.
- Review and documented treatment progress, update ISP, and review/update the crisis prevention plan, as appropriate.
- Requested continued service is determined medically necessary by MHP, and must meet all of the following:
    1. Current ACS covered diagnosis.
    2. Current symptoms (resulting from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued.
    3. Current symptoms and history demonstrate continued treatment is necessary to maintain gains in functional ability, maintain community safety, or to avoid hospitalization.
    4. Intervention is deemed necessary to improve or stabilize functioning resulting from a covered mental health diagnosis.
    5. The individual is expected to benefit from the intervention.
    6. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).
    7. SBHO adopted Practice Guidelines recommend continued treatment.

In addition to the above, Non-Medicaid individuals will only be authorized continuing care if there are sufficient resources and meet ONE of the following additional criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison.
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization
5. Applied for Medicaid and enrollment decision is pending

Type of Services/Modalities

- Intake assessment, group treatment, brief intervention treatment services, medication management, medication monitoring, and psychoeducation.

Intensity of Service

- Brief intervention and/ or low intensity mental health services

Duration of Episode

- Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Low intensity: Maximum of 24 individual service hours for 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists (ethnic minority, disability). CMHA submits a PRAT (identifying requested service level, determination of ACS requirements and medical necessity) to SBHO delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation and then provides an authorization determination within 14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests, when indicated.
- Written notification of authorized services is provided via mail.

Adult Services
Level 2 Outpatient Services

Service Description

- Long Term Rehabilitation is necessary to achieve or maintain stability in the community. Intense level of acute outpatient treatment may include active outreach and intensive services to prevent hospitalization, out of home placement, reinforce personal and community safety, and promote the stability and independence of an individual in the community while decreasing the use of other costly services.
  Authorization benefit: More than 24 service hours in 12 months.

Routine Admission Criteria

- Individuals must meet the Access to Care Standard (ACS), and the requested service is determined medically necessary by MHP.

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria may be authorized for Level 2 services (reference Child/ Youth LOC for criteria and requirements):

In addition to the ACS, Non-Medicaid individuals will only be authorized if there are sufficient resources and they meet at least ONE of the following criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison.
4. A Mental Health Professional determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Applied for Medicaid and enrollment decision is pending

- Safety/ Risk Assessment. In addition to the above criteria, one of the following qualifying risk factors must apply for an individual:
  1. Current severity of symptoms makes the individual at risk for hospitalization, if services are not provided at this level
  2. More than 3 contacts with the provider crisis team in the previous month
  3. Psychiatric hospitalization in the previous 3 months
  4. Current suicidal or homicidal ideation, or history of an attempt

Continuing Stay Criteria

- Continuing Stay criteria only apply for continuation of previously authorized level or less intensive level of care.
- Review and document treatment progress, update ISP, and review/update the crisis prevention plan, as appropriate.
- Requested continued service is determined medically necessary by MHP, and must meet all of the following:
  1. Current ACS covered diagnosis.
  2. Current symptoms (resulting from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued.
  3. Current symptoms and history demonstrate continued treatment at this level is necessary to maintain gains to maintain community safety or to avoid hospitalization.
  4. Intervention is deemed necessary to improve or stabilize functioning resulting from a covered mental health diagnosis.
  5. The individual is expected to benefit from the intervention.
  6. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).

In addition to the ACS, Non-Medicaid individuals will only be authorized if there are sufficient resources and they meet at least ONE of the following additional criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Applied for Medicaid and enrollment decision is pending

Type of Services/Modalities

- Includes all allowable outpatient services under the state plan; full scope of outpatient treatment modalities and level of intensity is provided based on clinical assessment, medical necessity and individual needs.

Intensity of Service

- Continuum of high intensity and comprehensive mental health services

Duration of Episode

- Minimum of 24 individuals service hours in 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA submits a PRAT (identifying requested service level, determination of ACS requirements and medical necessity) to SBHO delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation, then provides an authorization determination within 14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests, when indicated.
- Written notification of authorized services is provided via mail.

Adult Services
Level 1 & 2 Services
Expedited Reviews: Admission & Continuing Stay for Medicaid

MEDICAID ONLY (42 CFR 438.210)

This Level of Care applies to expedited authorization reviews for admission and continuing stay for Level 1 and 2 outpatient services.

Service Description

- For cases in which a network provider (CMHA) indicates that the following the standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the CMHA MHP must make an expedited authorization request for services, indicating urgent or emergent review status, and provide an authorization request as expeditiously as the individual's health condition requires.
- Crisis services can be provided while the expedited authorization request is pending.

Expedited Admission Criteria

- Individuals with Medicaid coverage, only.
- The standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function
- For admission authorization determination: Must meet Access to Care Standards (ACS) for Admission into Level 1 or 2 services criteria (medical necessity criteria, functional impairment, and diagnosis)
- For continuing stay authorization determination: Must meet continuing stay criteria, as defined by the requested level.
- Requested service is determined medically necessary by MHP

Type of Services/Modalities

- Level 1: Intake assessment, group treatment, brief intervention treatment services, individual and family services, medication management, medication monitoring, psychoeducation, family/ peer supports.
- Level 2: Includes all allowable outpatient services under the state plan. The full scope of outpatient treatment modalities and level of intensity for each modality may be provided based on clinical assessment, medical necessity and individual needs.
    - EPSDT referred Level 2 services for Medicaid youth can require establishing a formalized Individual Service Team for each child/ youth to further develop a cross system Individual Treatment plan (refer to Child/ Youth LOC for criteria and requirements)

Intensity of Service

- Level 1: Brief intervention and low intensity mental health services
- Level 2: Service intensity is individualized, based on *continued* assessment of need and adjustments are reflected in the ISP.

Duration of Episode

- Level 1 Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Level 1 Low Intensity: Maximum of 24 individual service hours within 12 months
- Level 2 Long Term Rehabilitation: Minimum of 24 individuals service hours in 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts an intake evaluation by an MHP that establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA telephonically provides or forwards a completed PRAT request with the urgency category flagged to the SBHO ASO. All telephonic information is followed-up with the required documentation.
- ASO immediately reviews the PRAT information, diagnosis information and any additional clinical documentation to support the request, prior to making a service determination, within 3 days from the request.
- ASO provides an authorization determination within 3 working days from the date of request for mental health services. The CMHA may extend the 3 day time period up to 14 calendar days if the individual applying for services requests an extension, or if the provider justifies a need for additional information and how the extension is in the individual's interest.
- Written notification of approved or denied services is provided via mail.

Adult Services
Level 1 & 2 Services
Inactivation & Reactivation of Services

Service Description

- Clinical inactivation refers to an individual who has left services within an authorized benefit period. Clinical inactivations can occur at any point throughout an authorized episode of treatment. *When there has been no direct services provided for authorized episodes over 90 days, the SBHO strongly recommends supervisory review and consideration for administrative closure.*
- Administrative inactivation refers to the expiration of an authorized benefit period (6 or 12 months). In rare occurrences, an administrative inactivation is requested when an individual moves out of the catchment area (including entering the prison system) or dies within an authorized benefit period.
- Reactivation refers to re-opening a previously clinically inactivated case, within the initial authorized benefit period.

Inactivation Scenarios

- Applies to Medicaid and Non-Medicaid individuals.
- Clinical inactivations may occur when any of the following apply:
  1. The client met their expected treatment goals/outcomes
  2. The client is over the age of 13 years and requests inactivation of treatment
  3. The client is not participating in treatment, has not responded to engagement efforts, and imminent risk issues are not present
  4. The client's whereabouts are unknown, and three attempts to contact them (by two different means) have been unsuccessful
  5. The client's treatment needs can be met through other services available within their support system; care is being/ has been transitioned to another entity
- Administrative inactivations may occur when any of the following apply:
  1. The client does not meet continuing stay criteria and the benefit period expires
  2. The client has moved out of the SBHO
  3. The client is deceased

Reactivation Criteria

- Applies to Medicaid and Non-Medicaid individuals. The request for reactivation is made by a MHP or the primary clinician, under the supervision of a MHP. Non-Medicaid individuals may only be re-activated if there are sufficient resources to support the re-activation service plan.
- Reactivation summary is required to document current information. No additional authorization is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Authorization Protocols

- Inactivations
  - CMHA records the clinical inactivation and discharge summary in the clinical record and Profiler system.
  - The ASO generates a monthly report to identify individuals with pending administrative inactivations. After 10 days, if the Medicaid individual does not contact the ASO or CMHA requesting on-going services the inactivation is processed/ authorized.
- Reactivations
  - Reactivation documentation is present in the clinical record and re-activation status is entered into Profiler. No additional authorization is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Adult Services
Community Hospital Inpatient Services - Voluntary & Involuntary

Service Description

- Community hospitalization services for adults include evaluation, stabilization and treatment services and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- A SBHO network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalizations must be made by a MHP

Voluntary Admission Criteria

Voluntary inpatient admissions must meet all of the following baseline criteria:

1. The existence of a DSM-5 disorder.
2. Evidence that the admission is medically necessary.
3. The individual poses an actual or imminent danger to self, others or property due to a mental disorder, or
   The individual has experienced a marked decline in ability to care for self due to the onset or exacerbation of a psychiatric disorder.
4. There is a verified failure of treatment at a lesser level of care, or
   A DMHP determines severity of symptoms, intensity of treatment or lack of supports cannot be provided at a lesser level of care.
5. Medical evaluation determines that the individual's current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When an individual may *exceed* the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The inpatient facility is responsible for requesting an extension at least 24 hours prior to the expiration date. The inpatient facility must contact the designated network CMHA to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. The continuing care/ extension request is case specific and there is no range for authorization.

- At least one of the following criteria must be present for continuing stay authorization:
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The individual continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The individual demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The individual 's level of functioning has regressed since admit
  5. The individual continues to need re-stabilization to reach baseline functioning and further improvement in condition is expected.

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met or unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat to the individual, others or property and the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, an individual can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, an individual must meet continued stay criteria to be authorized
- *A new certification number must be requested* and is automatically issued to differentiate between inpatient facilities and legal status changes.

Retro-authorizations

A community hospital may request retro-authorization reviews. For out of state retro-authorization requests, the request must be made within three months of discharge.

1. The retro-authorization determination can take up to an additional 30 days.
2. Individual currently admitted to inpatient facility, CommCare may provide a verbal review and retro-authorization.
3. Individual discharged from inpatient facility, CommCare requires hospital documentation for comprehensive review and determination

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care.

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) for 20 days.
- For voluntary hospitalizations, the standard benefit period for admission and extension requests is determined and requested by the CMHA crisis team (standard range is 1 to 3 days).

Authorization Protocol

- The ASO collects the necessary information for Provider 1 Prior Authorization from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation.
- ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day.

Adult Services

Adult Inpatient Unit (Network E&T) - Voluntary & Involuntary

Service Description

- Inpatient hospitalization for adults at Kitsap Mental Health Services (KMHS) Adult Inpatient Unit (AIU) that include evaluation, stabilization and treatment and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- The SBHO network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient requests.
- All voluntary hospitalizations must be made by a MHP

Voluntary Admission Criteria- up to a standard 20 day initial authorization . Voluntary inpatient admissions must meet all of the following baseline criteria:

1. The existence of a DSM-5 disorder.
2. Evidence that the admission is medically necessary.
3. The individual poses an actual or imminent danger to self, others or property due to a mental disorder, or
   The individual has experienced a marked decline in ability to care for self due to the onset or exacerbation of a psychiatric disorder.
4. There is a verified failure of treatment at a lesser level of care, or
   A DMHP determines severity of symptoms, intensity of treatment or lack of supports cannot be provided at a lesser level of care.
5. Medical evaluation determines that the individual's current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When an individual may *exceed* the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The E&T must contact the network CMHA that initiated the admission to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. The continuing care/ extension request is case specific and there is no range of days for authorization.

- At least one of the following criteria must be present for continuing stay authorization:
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The individual continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The individual demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The individual 's level of functioning has regressed since admit
  5. The individual continues to need re-stabilization to reach baseline functioning and further improvement in condition is expected.
- Once an individual is admitted to the E&T, the CMHA must contact the E&T to begin coordinating care within one business day. .

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met or unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat to the individual, others or property and the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, an individual can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, an individual must meet continued stay criteria to be authorized for 20 days
- *A new certification number must be requested* and is automatically issued to differentiate between inpatient facilities and legal status changes.

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care.

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) and LOS is determined by court order.
- For voluntary hospitalizations, the benefit period is up to 20 days for admission and extension requests are requested by the CMHA/ determinations are made by the ASO.

Authorization Protocol

- Only the network CMHA can request authorization for inpatient E&T services, all other parties must facilitate their request through CMHA.
- The ASO collects the necessary information for an inpatient certification from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation. All extension requests must be submitted to the SBHO for review 3 calendar days prior to the expiration. Upon SBHO review, the request is forwarded to CommCare for authorization.
- The ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize

administrative days.

- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day. SBHO conducts 100% review of all NOAs and tracks appeals.

Adult Services

Residential Services: Brief & Long Term Intensive

Service Description

Residential services are services provided to assist individuals living in community-based settings, like Keller House and Arlene Engel House. Residential services differ from other services in terms of location and duration. Residential services can be brief or long-term:

Brief Residential Service is defined as residing 28 days or less at a facility.

Long Term Intensive Service is defined as residing 180 days or less (within 6 months) at a residential facility.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage. *Non-Medicaid individuals will only be authorized within available resources.*
- Must meet Access to Care Standards (ACS) or admission to outpatient services (medical necessity criteria, functional impairment, and diagnosis)
- Must be requested service by MHP and deemed medically necessary. An individual must demonstrate one of the following to be admitted:
    1. The presenting signs of a psychiatric illness clearly demonstrate a need for residential level structure, supervision and treatment that cannot be stabilized at a lesser level of care.
    2. The individual has a history or recent episode of failing to live independently in the community due to his/her psychiatric illness.
- In addition to the above criteria, all the following must apply:
    1. The individual is an adult age 18 years or older.
    2. The individual is ambulatory and does not require physical or chemical restraints.
    3. The individual has adequate cognitive functioning to enable him/her to respond to fire alarms and evacuate the premises without emergency assistance.
    4. The individual is currently enrolled in outpatient services and has a current Crisis Plan, or is in the process of being authorized and assigned to outpatient services.

Exclusion Criteria

If an individual demonstrates any of the following, they are excluded from residential services: However, the exclusion can be waived based on the individual's level of functioning.

1. *The individual has a psychiatric condition that qualifies for a higher level of care.*
2. *The individual is actively suicidal and/or homicidal, per MHP staff assessment.*
3. *The individual has a recent history of a pattern of assault/violent behaviors toward self or others.*
4. *The individual has a physical condition requiring medical or nursing care available only in a hospital or other more intensive nursing environment. Cases requiring limited medical or nursing care will be evaluated on an individual basis by SBHO Registered Nursing (RN) staff.*
5. *The individual is in need of detoxification.*
6. *The individual has a history of being a sexual predator or* of committing arson.

Continuing Stay Criteria

At least one of the following criteria must be met:

1. Admission criteria for residential services continues to be met.
2. The individual must have a treatment plan that identifies need and measurable goals for residential services. The individual must be making progress toward treatment goals.
3. For supported living homes, the individual may choose to stay for an extended period while enrolled in an outpatient episode of care.

Discharge Considerations

- One of the following must be met for discharge from residential services:
    1. The individual's residential treatment goals have been sufficiently met.
    2. The individual no longer meets admission or continuing stay criteria for residential services, or meets criteria for a less/more intense LOC.
    3. There is an appropriate discharge plan to a less restrictive level of care that identifies components for maintaining treatment gains.
    4. Consent for treatment is withdrawn, and it is determined that the individual does not meet the criteria for residential treatment.
- If the individual is non-compliant in treatment or in following the residential program rules and regulations, despite treatment attempts to address non-compliance issues, they may be discharged to a more/less intensive level of care.

Type of Services/Modalities

- Residential program that includes therapeutic, medical, and assisted living for individuals.

Authorization Protocol

- The SBHO residential authorization requirements will not conflict with or overrule Boarding Home licensing requirements. Evictions will be in compliance with Boarding Home WAC 388-78A-2660 (Residents Rights) and applicable Landlord/Tenant laws.
- CMHA determines funding eligibility, establishes medical necessity, and identifies placement.

- CMHA submits a PARS form (identifying requested residential service level, documenting criteria requirements and medical necessity) to SBHO delegated ASO.
- ASO reviews PARS and supporting documentation prior to authorization determination. ASO provides an authorization determination within 14 calendar days from the date of request for services.
- With a service denial, the ASO mails written notification to the individual.

Adult & Child/Youth Services

Crisis & Stabilization

Respite

Adult & Child/Youth Services
Crisis & Stabilization

Service Description

- A crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate intervention.
- Stabilization services are to be provided in the person's own home, or another home-like setting, or a setting that provides safety for the individual and the mental health professional. Stabilization services may include ancillary crisis services to cover costs for room and board.
- SBHO network CMHAs mental health crisis response teams are authorized to coordinate stabilization services. The CMHAs may coordinate crisis stabilization services outside their designated areas, and within the network, in order to ensure access and availability.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage.
- For stabilization services to be provided, all of the following baseline criteria must be met:
  1. The individual is in crisis, as defined above.
  2. The stabilization services will prevent further deterioration.
  3. The stabilization services are located in the best-suited and least restrictive environment.
  4. The stabilization services are medically necessary, as determined by a MHP.
  5. The individual does not meet criteria for a more intensive level of care.
  6. The individual agrees to participate in the voluntary stabilization service(s).
  7. A description of the stabilization services that are to be provided with an estimate length of the service(s) duration, up to 14 days per episode, is documented in the crisis/ clinical chart.

Admission Exclusion Criteria

- Stabilization services are not provided if any of the following apply:
  1. The individual is in need of medical stabilization for physical/organic dysfunctions beyond the scope and resources of the stabilization service(s).
  2. The individual is assessed to be in need of an inpatient facility.
  3. The individual is in need of drug/alcohol detoxification.
  4. When an individual exceeds the initial authorization amount and a request for continuing stay is made, at least one of the following criteria must be met.

Continuing Stay Criteria

- All of the following must apply:
  1. Admission criteria for this level continues to be met.
  2. A description of explaining the continued need for the stabilization service(s) with an estimated length of the service(s) duration documented in the crisis/clinical chart.
- When an individual exceeds the initial planned amount (up to 14 days), continuing stay is required to continue to provide the stabilization services.

Discharge Considerations

- Any of the following may lead to a discharge of stabilization service(s):
  1. The individual no longer meets admission criteria.
  2. The individual requires a less/more restrictive level of care.
  3. There is a reasonable plan for follow-up services, in or outside the network, identified. .
- The individual requests discharge/ termination of stabilization service(s). If a child, the caregiver requests discharge/ termination of stabilization service(s).

Type of Services/Modalities

- Stabilization services include short-term (up to 14 days, per episode) face-to-face assistance with life skills training and/ or understanding of medication effects.

Authorization Protocol

- Stabilization services are considered a crisis service modality available to all residents of the SBHO.
- Crisis stabilization services do not require authorization from the SBHO and can be provided prior to an intake assessment.
- The CMHA MHP determines when stabilization services are medically necessary for initial and continuing stay.
- Initial authorization cannot exceed14 days and continuing stay cannot exceed 14 days, per episode. Only one episode can be authorized at a time.

Adult & Child/Youth Services
Respite

Service Description

- Respite Care services are used to sustain the primary caregivers of children and youth with emotional disorders or adults with mental illness. Respite care is provided in a manner that provides necessary relief to caregivers. Respite services include providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of a individuals by someone other than the primary caregivers. Respite services are provided by, or under the supervision of, a mental health professional.

  Respite services may be provided in a variety of settings, such as the caregiver's home, in an organization's facilities, or in the respite worker's home. The care should be flexible to ensure that the individual's daily routine is maintained. Respite services may be provided on a planned or an emergent basis and are voluntary.

- Only SBHO network CMHAs are authorized to provide respite services. All other interested parties must facilitate their requests through the CMHAs.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage.
- For respite care service(s) to be provided, all of the following standard criteria must be met:
  1. The individual must be currently authorized for SBHO funded outpatient care, the expedited admission review process can be used
  2. The respite care services are medically necessary.
  3. The individual does not meet criteria for a more intensive level of care.
  4. The individual agrees to participate in the voluntary respite care service(s).
  5. A description of the respite care service(s) that are provided with an estimate length of the service(s) duration is documented in the clinical chart.
- In addition to the required criteria listed above, at least one of the following must apply:
  1. The individual's caregiver has no other respite options available at the time of the needed service.
  2. The individual faces a potential crisis such as a housing emergency, significant loss, etc. and without respite support would be at significant risk for decompensation and potential hospitalization.
  3. The individual is in need of continuous support and supervision during a medication titration.

Admission Exclusion Criteria

- Respite care services are not provided if any of the following apply:
  1. The individual is in need of medical stabilization for physical/organic dysfunctions beyond the scope and resources of the respite service.
  2. The individual is assessed to be in need of an inpatient facility
  3. The individual is in need of drug/alcohol detoxification.

Continuing Stay Criteria

- All of the following must apply:
  1. Admission criteria for this level of care must continue to be met.
  2. The individual must have a treatment plan that identifies need and measurable goals for respite care services. The individual 's progress toward treatment goals is based on the effectiveness of the respite services to the overall treatment plan.

Discharge Considerations

- Any of the following may lead to a discharge of respite service(s):
  1. The individual no longer meets respite admission criteria, or outpatient authorization expired and does not meet criteria for continued outpatient services.
  2. The individual requires a less/more restrictive level of care.
  3. The plan for the respite service was successfully completed.
  4. There is a reasonable plan for follow-up services in place.
  5. The individual requests discharge/ termination of respite service(s). If a child, the caregiver requests discharge/ termination of respite service(s).

Type of Services/Modalities

- Respite services include providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of a individual by someone other than the primary caregivers.

Authorization Protocol

- Respite services are authorized with outpatient services, no additional authorization is required.
- A Respite benefit period is the same as the authorized outpatient services benefit period.
- Reference LOC for Outpatient Services.