



## Supplemental Clinical Criteria: Washington Medicaid

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## INTRODUCTION AND INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria* defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by UnitedHealthcare.

Other *Clinical Criteria* may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by UnitedHealthcare. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

## MENTAL HEALTH: INPATIENT

**Please apply LOCUS/CASII/ECSII and refer to the following requirements for Washington.**

**Institutes for Mental Disease (IMD):** An institution for mental diseases such as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. An IMD is a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

**Children's Long-Term Inpatient Program (CLIP):** CLIP is an inpatient program that provides inpatient care for children and youth between the ages of 5-18 who need extended inpatient mental health services. CLIP services are intended to promote discharge from inpatient care, maximize treatment benefits, minimize the risk of readmission and increase length of time in the community. The CLIP liaison is the primary contact for the treatment team and will manage cases from preadmission through discharge. In the case of a CLIP admission from a Washington Tribal Authority, the liaison will work with the tribe during discharge planning to provide appropriate services to the member.

### Admission Criteria

- The member's condition and /or the member's history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
  - A life-threatening suicide attempt;
  - Self-mutilation, injury, or violence towards others or property;
  - Threat of serious harm to self or others;
  - Command hallucinations directing harm to self or others.

OR

- The member's condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
  - A physical cause for the member's signs and symptoms cannot be ruled out in a less intensive setting;
  - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting;

OR

- The factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:
- Impairment of behavior or cognition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered;
- Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care;

OR

- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.
- For IMD, the member is either under the age of 21 or over the age of 65.
- For IMD the member meets all of the above criteria and will likely not need inpatient care for more than 15 days.
- For CLIP services, the member is under the age of 19 who is in foster care or in an out of home placement; and/or receiving services through a family-centered, community based coordinated care; or
- For CLIP services, it has been determined that the member may benefit from CLIP services after being court committed for involuntary treatment for 180 calendar days.
- For CLIP services, the member receives Rehabilitation Case Management throughout the CLIP stay in coordination with the treatment team.

### **Continuing Stay Criteria**

- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
  - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
  - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;
  - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- For CLIP services, the facility continuously considers less restrictive treatment options during the member's stay.

### **Discharge Criteria**

- An IMD admission is not longer than 15 calendar days or less within the same calendar month.

### **Service Delivery**

- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.
- During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.
- For CLIP, services include:
  - Ongoing assessment for discharge

- Work toward admission into community mental health care
- Integrated mental health treatment planning
- Resource identification
- Linkage to mental health rehabilitative services; and  
Development of individualized services that promote continuity of mental health care.

## MENTAL HEALTH SERVICES FOR TREATMENT-RESISTANT DEPRESSION

### **Repetitive Transcranial Magnetic Stimulation (rTMS) and Electroconvulsive therapy (ECT)**

are two non-pharmacologic treatments for treatment-resistant depression covered for clients age 19 and older who do not respond to the following antidepressant medications:

- Treatment-resistant is defined as depression that is unresponsive to trial therapy at a maximum tolerated dose for 4-12 weeks of one antidepressant from two of the following five classes:
  - Selective Serotonin Reuptake Inhibitors (SSRI)
  - Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
  - Noradrenergic and Specific Serotonergic Antidepressant (NaSSA)
  - Norepinephrine/Dopamine Reuptake Inhibitor (NDRI)
  - Serotonin Antagonist Reuptake Inhibitor (SARI)

Failed trials require a level of compliance considered adequate by the provider, and may include failures that did not meet the duration requirement due to adverse events or reactions.

- rTMS is considered covered in the following circumstances:
  - Limited to 30 visits in a seven-week period followed by 6 taper treatments
  - Must be ordered and performed by a psychiatrist or a P-ARNP
  - Must be performed in outpatient settings only
- rTMS is not considered medically necessary when:
  - Psychotic symptoms are present in the current depressive episode
  - Conductive, ferromagnetic or other magnetic-sensitive metals are implanted in the client's head which are nonremovable and are within 30 cm of the TMS magnetic coil. (Examples include: cochlear implants, implanted electrodes/stimulators, aneurysm clips or coil, stents, and bullet fragments)
  - The client is diagnosed with Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder
  - Other neurological conditions exist (e.g. Epilepsy, Parkinson's disease, Multiple Sclerosis, Cerebrovascular disease, Dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, primary or secondary tumors in the central nervous system, or any other degenerative neurologic condition)
  - Used as a maintenance therapy
  - The client is an active substance user

For further best practice and guidance, please see the [Optum Behavioral Clinical Policy: Transcranial Magnetic Stimulation](#).

- Electroconvulsive therapy (ECT) is covered when all of the following are met:
  - Provided by a psychiatrist
  - Offered inpatient or outpatient
  - Documentation exists supporting other treatments have been unsuccessful

## WRAPAROUND SERVICES WITH INTENSIVE SERVICES (WISe)

**WISe** is designed to provide comprehensive behavioral health services and supports to members and their families up to 21 years of age with complex behavioral health needs. The goal of WISe is for the member to live and thrive in their home and community, as well as to avoid or reduce disruptive out-of-home placements.

The core elements of WISe include each of the following phases:

- Engagement
- Assessing
- Teaming
- Service Planning and Implementation
- Monitoring and Adapting
- Transition

WISe services are intensive or direct services provided in home and community settings. Intensive services ("direct services") provided in home and community-based settings. They are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a youth's functioning, or provided in order to maintain or restore functioning. Interventions are aimed at promoting health and wellness and helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community.

Direct services are delivered according to an Individualized Service Plan, coordinated with the Cross System Care Plan to deliver integrated Wraparound with Intensive Services. The CFT develops goals and objectives for all life domains in which the youth's mental health condition produces impaired functioning (including family life, community life, education, vocation, and independent living) and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives seek to maximize the youth's ability to live and participate in the community and to function independently by building social, communication, behavioral, and basic living skills. WISe Practitioners should engage the youth in home and community activities where the youth has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

### Admission Criteria

- The member is under the age of 21 and has complex behavioral healthcare needs that may include:
  - Involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, developmental disabilities, special education, substance use disorder treatment).
  - More restrictive services have been requested, such as psychiatric hospitalizations, residential placement or foster care placement, due to mental/behavioral health challenges.
  - Risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
  - Significantly impacted by childhood or adolescent trauma.
  - Prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
  - History of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
  - Risk factors such as suicidal ideation, danger to self or others, behaviors due to mental/behavioral health challenges.
  - Family requests support in meeting the youth's mental/behavioral health challenges.

## **Service Delivery**

### ***WISe Screening***

- A WISe screen must be offered within 10 business days of receiving a referral.
- All WISe screens include:
  - Information gathering that utilizes the information provided by the referent (i.e. the youth, a family member, a system partner, and/or an informal or natural support). Additional information may be gathered from the youth and family directly and others who have been involved with the family (including extended family and natural supports) and/or its service delivery.
  - Completion of the Child Adolescent Needs and Strengths (CANS) Screen, which consists of a subset of 26 questions, pulled out the full CANS assessment. The CANS screen must be completed by a CANS-certified screener.
  - Entering the CANS Screen into the Behavioral Health Assessment System (BHAS) which will apply the CANS algorithm to determine whether the youth would benefit from WISe.
  - All youth who meet the CANS algorithm and the MCE's qualifying criteria will be determined to meet WISe level of care. If a youth does not meet the CANS algorithm, clinical judgment may be used to continue with a referral to WISe.
- Once the member has been screened into WISe, engagement includes steps to:
  - To lay the groundwork for trust and shared vision among the youth, family and WISe team.
  - To establish rapport and build commitment to WISe process through warmth, optimism, humor, and identification of strengths.
  - The WISe Practitioner(s) meet with the youth and family to explain the WISe process, and how it differs from traditional care.
  - The WISe Practitioner(s) obtains consent for services.
  - The WISe Practitioner(s) discuss with the youth and family the events, circumstances, and moments that brought the youth and family to WISe.
  - The WISe Practitioner(s) obtain the youth and family perspective on where they are presently (including listening for both their expressed needs and strengths), and where they would like to go in the future.
  - The WISe Practitioner(s) discuss the youth's and family's view of crises, and develops a written plan to stabilize dangerous or harmful situations immediately.
  - The WISe Practitioner(s) ensure the youth and family understand any system mandates (if applicable) and ethical issues.

### ***WISe Assessing***

- The WISe Practitioner(s) complete a strengths discovery and a list of strengths for all family members.
- The WISe Practitioner(s) discuss and lists existing and potential natural supports.
- The WISe Practitioner(s) complete a list of potential team members.
- The WISe Practitioner(s) summarize the youth and family context, strengths, needs, vision for the future, and supports.
- The WISe Practitioner(s) determine with the youth and family how the CANS information will be provided to the team.

### ***WISe Teaming***

- The WISe Practitioner(s) explain WISe to potential team members, eliciting their perspectives, and working to get their commitment to participate in the team process.

- The WISE Practitioner(s) invite potential team members to join the team process.
- The WISE Practitioner(s) partner and orient team members to the WISE process and team meeting structure.
- The CFT members help to create the team meeting agenda, provide input about the meeting logistics and provide comfort for youth and family.
- The CFT will include the youth, parents/caregivers (see definitions in Appendix B), relevant family members, and natural and community supports.
- The CFT will be expected to meet with sufficient regularity (every 30 calendar days, at a minimum), as indicated in the CSCP, to monitor and promote progress on goals and maintain clear and coordinated communication.
- The CFT reviews the interventions and action items and adjusts these accordingly, using the outcomes/indicators associated with each priority need, included in the CSCP. A WISE Practitioner guides the team in evaluating whether selected strategies are promoting improved health and wellness for the youth and successfully assisting in meeting the youth and family's identified needs.
- The CFT works together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and family.
- The CFT has a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services.
- The WISE Practitioner(s) are expected to check in with team members on progress made on assigned tasks between meetings.
- The WISE Practitioner(s) set a time, date and location for the team meeting that is convenient to the youth and family.

### ***Service Planning and Implementation***

- The WISE Practitioner(s) meet with the youth and family and develops a list of possible needs of the family prior to the team meeting, based on the results of the CANS assessment.
- The WISE Practitioner(s) convene one or more team meetings to discuss and obtain agreement on the elements of the CSCP.
- In the CFT meeting, the youth and family's vision for their future is presented.
- The CFT discusses and sets ground rules to guide the meetings.
- The CFT reviews and expands the list of strengths for the youth and family.
- The CFT creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISE.
- The CFT reviews the list of needs and agrees which to prioritize in the CSCP, respecting and including the preferences and priorities of the youth and family.
- The CFT determines the intended outcomes that will transpire when the needs are met.
- The CFT brainstorms an array of strategies to meet these needs, and then prioritizes strategies for each need, including the use of natural supports and intensive services.
- CFT members agree upon assignments, or action steps, around implementing the strategies.
- The CFT evaluates the crisis plan and adapts as necessary.
- The work of the team is documented, and distributed among team members.

### ***Monitoring and Adapting***

- The CFT continues to meet at a minimum of every 30 calendar days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
- The CFT adjusts strategies to meet changes in the needs and outcomes. The team adds, subtracts and modifies strategies to create the most effective mix of services and supports.
- The CFT evaluates whether there is progress towards the designated outcomes. The team adjusts the strategies to guide next steps.

- The CFT adds members, as necessary and appropriate, and strives to create a mix of formal, informal, and natural supports.
- The CFT celebrates successes and adds to strengths as they are identified.
- Full CANS assessments are administered and entered into BHAS every 90 days to help track progress, and to catch emerging needs and make changes to the plan as necessary.
- The WISE Practitioner(s) maintain ongoing communication outside of the team meetings to best monitor “buy-in” , and to ensure that all members’ perspectives are heard.

### ***Direct Services and Settings***

- Direct services include, but are not limited to:
  - Educating the youth's family about the mental health challenges the youth is experiencing, and how to effectively support the youth.
  - In-home functional behavioral assessment.
  - Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family and others how to implement behavioral strategies, and in-home behavioral aides who assist in implementing the behavior plan, monitor its effectiveness, and report on the plan's effectiveness to clinical professionals.
  - Therapeutic services delivered in the youth' s home or community including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence-/research-based practices (e.g., Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy, Family Functional Therapy, etc.). These services are designed to:
    - Improve self-care, by addressing behaviors and social skills deficits that interfere with daily living tasks and to avoid exploitation by others.
    - Improve self-management of symptoms including self-administration of medications.
    - Improve social functioning by addressing social skills deficits and anger management.
    - Reduce negative effects of past trauma, using evidence-/research-based approaches.
    - Reduce negative impact of mental health disorders, such as depression and anxiety, through use of evidence-/research-based approaches.
    - Support the development and maintenance of social support networks and the use of community resources.
    - Support employment objectives by identifying and addressing behaviors that interfere with seeking and maintaining a job.
    - Support educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program in the community.
    - Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.
- Direct services will be provided in any setting where the youth is naturally located, including the home, schools, recreational settings, childcare centers, and other community settings wherever and whenever needed, including in evenings and on weekends.



**Assertive Community Treatment (a.k.a. Program of Assertive Community Treatment, PACT, ACT):** Program of Assertive Community Treatment (PACT) is a self-contained mental health program made up of transdisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. PACT services are individually tailored with each consumer through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the consumer to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for consumers. The consumers served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 10 consumers to one staff member on each urban team and no more than 8 consumers to one staff member on each rural team.

### **Admission Criteria**

- The member's condition indicates indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member primarily relies on the emergency room for behavioral health services.
  - Impairment of behavior or cognition interferes with Activities of Daily Living (ADLs) to the extent that the member requires significant support or assistance.

### **Continuing Stay Criteria**

- Ongoing assessment of symptoms and consumer's response to treatment.
- Modifying treatment to work with consumer within the consumer's contextual environment, i.e., to "meet consumer where consumer is at."
- Tracking, addressing, and documenting medication side effects.
- Providing education to the consumer and family about illness, meds, nature of treatment, etc.

### **Discharge Criteria**

- There is an inherent capacity and ability of the individual to recover and that is an expectation that PACT participants will get better and eventually not require PACT services.
- Discharges will occur when consumers and program staff mutually agree to the termination of services.
- Successfully reach individually established goals for discharge and when the consumer and program staff mutually agrees to the termination of services.
- Move outside the geographic area of the team's responsibility.
- Demonstrate an ability to function in all major role areas without requiring ongoing assistance from the program for at least one year without significant relapse when services are withdrawn.
- Decline or refuse services and request discharge, despite the team's best attempts to engage the consumer including efforts to develop an acceptable treatment plan with the consumer.
- Additional circumstances for discharge:
  - Death
  - Inability to locate the consumer for a prolonged period of time
  - Long-term incarceration
  - Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the PACT team that the consumer will not be appropriate for discharge for a prolonged period of time.

## Service Delivery

- There will be an initial assessment and treatment plan completed on the day of the consumer's admission to PACT by the team leader or the psychiatric prescriber, with participation by designated team members.
- The comprehensive assessment will be completed by a PACT team member and that the assessment is based upon all available information and completed within one month after consumer's admission.
- Treatment plans must be updated whenever there is a major decision point in the consumer's course of treatment (e.g., significant change in the consumer's condition or goals) or at least every 180 days.
- A comprehensive chemical dependency assessment will be conducted during the first month after a consumer is admitted to the PACT team.
- Each consumer will be assigned a primary practitioner who will be responsible for overall Service Coordination. The primary practitioner will be responsible for the following:
  - Ensuring treatment plan is written and kept current
  - Functions as lead provider of individual treatment services
  - Functions as lead worker with consumer's family
  - Responsible for maintaining consumer's chart, to include completion of treatment plan updates, maintaining consumer service authorization, completion of any required Outcome Data Forms, etc.
- The consumer is regarded as the owner of his or her treatment. This ownership shall include:
  - Taking a primary role in developing the treatment plan.
  - Playing an active and collaborative role in decision making regarding every aspect of his or her treatment.
  - The freedom to take risks.
  - Being empowered to learn, make mistakes, and rebuild life skills.
  - The freedom to make decisions and choices about their treatment and lives.
- Crisis intervention services will be provided to PACT consumers who are in crisis, provided in the least restrictive environment.
- The PACT team whenever possible will be the initial crisis responders, face-to-face or by telephone and whenever possible, a PACT team member will be present when a DMHP or external crisis provider is working with a PACT consumer.
- The PACT team endorses and supports the recovery aspects of supportive education and employment.
- Each consumer will be provided with support in activities of daily living and social and interpersonal relationships.
- The PACT team will facilitate and assist consumers in obtaining medical, dental care, housing, transportation, etc.
- The PACT team will provide education, support and consultation services to consumers and their families/supports.

## REFERENCES

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## REVISION HISTORY

Date	Action/Description
12/18/2018	<ul style="list-style-type: none"><li>• Version 1.</li></ul>
04/22/2019	<ul style="list-style-type: none"><li>• New RTF LOCG</li></ul>
12/13/2019	<ul style="list-style-type: none"><li>• Revised to clarify LOCUS/CASII/ECSII (draft)</li></ul>
08/24/2020	<ul style="list-style-type: none"><li>• Revised to clarify L/C/E used for RTF</li></ul>
02/15/2021	<ul style="list-style-type: none"><li>• Revised to add Services for Treatment-Resistant Depression</li></ul>