

CLINICAL CRITERIA INTRODUCTION

These clinical criteria are intended for use as a guide by ValueOptions® of California's Clinical Care Management staff in determining the medical necessity and appropriate level of mental health/substance abuse (MHSA) care for individuals receiving services through ValueOptions® of California programs.

The criteria sets contained in this manual provide guidelines for the provision of clinically appropriate least restrictive and cost-effective services that promote recovery from the symptoms of mental illness and addictive disorders, and lead to recovery or stabilization at the highest level of functioning. These criteria must be applied in conjunction with consideration of the individual's needs and characteristics such as age, cultural needs, co-morbidities and complications, the progress of treatment, desired outcomes, psychosocial needs, and home and/or work environment. Additionally, characteristics of the local delivery system available to the individual, including aspects such as availability of alternative levels of care, cultural preferences for treatment modalities, specialty providers, access to community resources, familial influences, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay must also be considered. Finally, determinations made using these criteria must be focused on principles of recovery and resiliency and consistent with existing ValueOptions® of California treatment guidelines and community standards.

ValueOptions® of California's approach to clinical care management is based on the premise that individuals are more likely to access appropriate services and remain engaged in treatment when they feel that their needs are understood and met. Through application of these criteria, ValueOptions® of California clinical staff and provider networks will be able to provide individuals with comprehensive and individualized services. These include assessment and referral to clinical practitioners and programs, coordinating a continuum of services, identifying community support resources including local support and/or self-help groups, identifying resources to meet basic needs, and making available educational materials concerning MHSA disorders.

Clinical Philosophy

ValueOptions® of California strives to enhance the well-being of the people we serve. We see ourselves as an integral part of the communities in which we provide service and understand that many factors impact the state of a person's health. To best serve a given population, we endorse principles of recovery and resiliency as we learn from, and work with, individuals in their communities in order to ensure relevant design of appropriate programs and services. We are

committed to supporting individuals in becoming responsible and active participants in their treatment.

The clinical philosophy of ValueOptions® of California is grounded in the provision of an understanding, compassionate environment in which the unique clinical and social needs of each individual are addressed in the context of hope and recovery. Our care management process is designed to ensure that consistent, high quality cost-effective services are provided in a culturally and linguistically competent manner. The foundation of our programs is based on:

- Clinical Excellence;
- Ethical Care;
- Professional Integrity;
- Clinical/Technical Innovation;
- Principles of Recovery and Resiliency; and
- Respect for cultural and linguistic preferences

ValueOptions® of California programs:

- Provide easy and early access to a comprehensive array of treatment and support services that includes consideration of the individual's social issues;
- Are based on the latest clinical evidence for treatment of mental illness and substance abuse;
- Monitor satisfaction with the utilization management process by individuals, consumers, practitioners, client companies, health plans, providers and agencies;
- Work collaboratively with providers in delivering quality care;
- Address the cultural needs of the members we serve;
- Address the needs of high risk special populations, such as children and adults with special health care needs due to physical or mental illnesses, adults aged 65 or older, non-elderly adults who are disabled, chronically ill individuals with developmental or complex physical needs, people with serious and recurrent mental illness, children in the child welfare system, and people in the military and their families;
- Encourage prevention, education and outreach;
- Focus on clinical and functional status and outcomes;
- Identify problems and promote best practices to create innovation and improvement;
- Focus on overcoming the negative impact of a psychiatric disability despite its continued presence for adults with serious and recurrent mental illness;
- Focus on building the ability to rebound from adversity, trauma, or other stresses and develop a sense of mastery and competence for children affected by mental illness; and

- Use an accountable, data-supported continuous quality improvement (CQI) process to accomplish all of the above.

Determining Medical Necessity

ValueOptions® of California clinicians must determine that proposed services are medically necessary according to the following definition:

Medically necessary services are those that are:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV-TR) that threatens life, causes pain or suffering, or results in illness or infirmity.
2. Expected to improve an individual's condition or level of functioning.
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
4. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
6. Not primarily intended for the convenience of the recipient, caretaker, or provider.
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
8. Not a substitute for non-treatment services addressing environmental factors.

Determining the Appropriate Level of Care

Four concepts underlie determinations of the appropriate level of care: 1) Severity of condition, 2) Intensity of service, 3) Psychosocial, occupational, and cultural and linguistic factors, and 4) Recovery and Rehabilitation. Taken as a whole, they enable Clinical Care Managers to make determinations based on an understanding of the individual's clinical, psychosocial, and related needs. Diagnosis alone does not determine the necessity of treatment at a given level.

Individuals with the same diagnosis or one individual over time may exhibit a wide range of severity of signs and symptoms of illness or psychosocial needs. The applicability of these criteria to each individual will depend on the information obtained by the ValueOptions® of California Care Manager from the individual, behavioral health and medical providers, family members, and other caregivers.

1. Severity of Condition

This concept addresses the question:

“What specific clinical condition exists as a result of a present DSM-IV-TR diagnosis?”

These represent the signs, symptoms, and functional impairments of such a nature and severity as to require treatment at a specified level at a given point in time. In addition, the presence of certain “high risk” clinical factors warrants consideration in evaluating an individual to determine his/her severity of condition. These factors include (but are not limited to):

- Repeated attempts at self-harm, with documented suicidal intent;
- Significant comorbidities (e.g., psychiatric/medical; psychiatric/substance abuse; psychiatric/mental retardation/developmental disability; substance abuse/medical; comorbid personality factors);
- Coexisting pregnancy and substance abuse disorder;
- Medication non-adherence;
- Unstable Axis I or II disorder;
- History of individual or family violence or assaultive behavior;
- Multiple family members requiring treatment;
- Decline in ability to maintain previous levels of psychosocial functioning; and
- Significant impairment in one or more areas of social functioning.

2. Intensity of Service

This concept considers the question:

“Does the individual’s condition and situation (e.g., behavior, symptoms, psychosocial and related issues) warrant this level of care (i.e., is it medically necessary)?”

The level of care should match the individual’s condition, taking into consideration his/her developmental strengths and limitations (e.g., physical, psychological, social, cognitive/intellectual, academic) and psychosocial and related needs. Intensity of services issues are represented in Admission, Exclusion, and Continued Stay Criteria and reflect levels of service that, by virtue of their complexity and/or attendant risks, require a specified level of care for their safe, appropriate, and effective application. For example, acute mental health inpatient services may be necessary for individuals with a condition that results in the expression of suicidal/homicidal ideas, threats, plans, or attempts. It is ValueOptions® of California’s expectation that treatment planning throughout a course of treatment is individualized,

specifically states what benefits the patient can reasonably expect to receive, and discharge planning is in place from the beginning of treatment planning. While some individuals' condition may be less serious, the presence of psychosocial, occupational, and cultural or linguistic factors (e.g., isolation, non-English speaking) may warrant customized treatment planning (see below).

3. Psychosocial, Occupational, and Cultural and Linguistic Factors

These considerations represent factors that are either aggravating an individual's clinical condition or need to be addressed in order to allow for effective treatment. An inappropriate or more intensive level of care may be the result if the issues are not addressed. These considerations address the question:

“What specific psychosocial, occupational, and cultural or linguistic factors are present that may change the risk assessment or may present a barrier to effective treatment and should be considered when making level of care decisions?”

The following factors and considerations identify common stressors/barriers but should not be considered exhaustive.

Psychosocial Factors

Psychosocial factors to consider when making level of care determinations include:

- Homelessness;
- Housing issues (e.g., risk of losing housing, inadequate housing, dissatisfaction with housing arrangements, hazardous living situation, placed at risk for abuse by current housing situation);
- Lack of effective social support (e.g., minimal social network, strained interpersonal relationships, abuse/neglect in living environment, family member/significant other with substance abuse disorder, single parent or non-parent family);
- Gender-specific issues;
- Physical disability;
- Financial difficulties;
- Lack of access to medical/dental care;
- Recent critical life event (e.g., sudden death of parent or child, divorce);
- Chronic illness;
- Isolation (e.g., rural resident, homebound);
- Lack of transportation;
- Lack of daycare;

- Active legal issues;
- Performance pressure at work or school and/or non-supportive school environment; and
- Recent release from a period of incarceration.

Occupational Factors

Workplace issues and/or requirements, when present, must be considered in determining the appropriate level and nature of service. When an internal or external Employee Assistance Program (EAP) exists or is involved, appropriate coordination of services with the EAP can be significant in facilitating an improved outcome. Workplace issues to consider include:

- Safety-sensitive position;
- Medical Leave of Absence (e.g., disability, workers' compensation);
- Performance pressure/non-supportive work environment;
- Child/Elder Care issues affecting employment;
- Supervisory referral;
- EAP referral;
- Regulatory compliance issues (e.g., Department of Transportation); and
- Work/treatment schedule conflict.

Cultural and Linguistic Assessment Considerations

Unbiased knowledge of the individual's culture and language is a prerequisite for an ethical and accurate assessment. Thus, cultural and linguistic competency are an integral part of all efforts to deliver services, and are a means of ensuring access, quality, cost effectiveness, and relevant outcomes. An understanding of the relationship between culture, health beliefs, health behaviors, help seeking, recovery, illness, rehabilitation, health policy, and social policy is necessary for timely, accurate and appropriate treatment planning and interventions. The importance of culture and language, the cultural strengths associated with people and communities, the assessment of cross-cultural relations, the cultural competence of providers, vigilance towards the dynamics inherent in cultural and linguistic differences, and the expansion of cultural and linguistic knowledge are critical.

The individual's qualities, characteristics and choices must not be ignored in efforts to develop and implement standards and guidelines. Only consistent, quality-driven efforts toward cultural competency can lead to the establishment of best practices. A culturally and linguistically competent assessment incorporates, at all levels, the adaptation of services to meet the individual's culturally and linguistically unique needs. As such, the individual should have the opportunity to receive an assessment and the appropriate services in his/her primary language.

When the individual's culturally specific customs and communication norms guide the information sharing process, the content and accuracy of the assessment and plan are enhanced.

4. Recovery /Rehabilitation/Habilitation

Principles of recovery, rehabilitation and habilitation need to be considered when deciding on the appropriate level of service and the necessary treatment plan. Rehabilitation is the process of building upon previous knowledge and strengths to improve one's quality of life. Habilitation is the process of learning new skills not previously possessed in order to improve one's quality of life. Staff respect the individual as the "the driver" of the treatment plan. If there are times when the individual is unable to function in an age or situationally appropriate role, a primary goal of treatment is to return that role to the individual as soon as possible. Treatment decisions should be based on the assumption that individuals can and will improve and can and will make choices about their care and their lives, and the treatment decisions should be designed to instill hope and pride. The individual's level of recovery, rehabilitation, or habilitation should be an important factor when making treatment decisions.

Evaluating Necessity for Continued Care

When evaluating the need for continued care, the Clinical Care Manager and primary behavioral health provider confirm that the treatment plan remains clinically appropriate and potentially effective or has been realistically and appropriately updated based on the member's response to treatment, and reflects any psychosocial, occupational, cultural or linguistic factors that affect the level of care determination. The following factors should be considered for continuation of a treatment plan:

- Coordination with other relevant providers;
- Individual is actively participating in the plan of care and treatment to the extent possible as consistent with the individual's condition;
- Progress in relation to specific symptoms or impairments is clearly evident and measurable, or stability at the maximum level of function has been obtained and can be sustained only by this level of care, or additional time is needed at this level of care to reach recovery goals;
- Active evaluation and treatment appropriate for the condition are occurring with involvement of the individual and his/her family or other support system, with timely relief of symptoms either evident or reasonably expected;
- Treatment plan includes documented expected benefit from all relevant modalities;
- Treatment or rehabilitation goals are realistic and established within an appropriate time frame for this level of treatment;

- Psychosocial, occupational, and cultural or linguistic issues are being addressed through timely referral to and coordination with workplace, community, and psychosocial rehabilitation resources (e.g., EAP, culturally specific treatment modalities, social service agencies, peer support, recovery/self-help groups, legal aid, credit counseling, assertive community treatment, warm lines, clubhouse programs, homeless shelters);
- Discharge planning is evident;
- All service and treatment modalities are carefully structured to achieve maximum results with the greatest efficiency in the use of resources so that the individual is treated at the least intensive level of care appropriate to the conditions and achieves the results desired (e.g., less intensive level of care, reunification of the family).

Discharge Criteria

ValueOptions® of California expects that active discharge planning begins at the point of admission and continues throughout the treatment course. The discharge criteria reflect the circumstances under which an individual is able to transition to a less intensive level of care or can be discharged from care. In the majority of these cases, the individual's documented treatment plan, goals and objectives will have been substantially met, and/or a safe continuing care program arranged and deployed at an alternate level of care. It is expected that the individual and significant others, as appropriate, are actively involved in both treatment and discharge planning. Discharge decisions and treatment alternatives are discussed with the individual throughout the course of treatment, and especially when discharge determinations are being considered. For some individuals whose condition has not stabilized but has intensified (e.g., exhibits severe behavior such as a suicide/homicide attempt), discharge will involve transition to a more intensive level of care. For children/adolescents in out-of-home placements, discharge may be prompted by reunification with parent(s), transition to an alternative living situation (e.g., foster care), or an independent living situation, or by symptoms (e.g., psychosis) that require a more highly structured setting. In the event that benefits are exhausted, a transition plan to alternative community based resources is developed and implemented.

Clinical Criteria Development

The clinical criteria contained in this manual were developed or adopted by ValueOptions® of California medical and clinical staff, based on information from: community clinicians with expertise in the diagnosis and treatment of individuals with mental illness and/or addictive disorders; national experts, internal experts in a particular subject area; standard clinical references; guidelines of professional organizations.

The criteria are reviewed and revised at least annually. This process includes ValueOptions[®] of California staff as they interact with providers around medical necessity determinations or receive input from Clinical Advisory Committees, as new modalities or programs are identified, or based on findings published by clinical organizations or academic institutions. Proposed revisions to the clinical criteria are presented to ValueOptions[®], Executive Medical Management Committee (EMMC). The EMMC meets monthly and is comprised of the Chief Medical Officers from each of ValueOptions[®] operating units, including ValueOptions[®] of California's Medical Director along with senior clinical representation from national departments and ValueOptions[®] of California. The Committee evaluates the proposed revision and may approve the criteria or suggest changes. The criteria are presented to ValueOptions[®] of California's Quality Management Committee for approval and adaptation. Once approved, it is posted on ValueOptions[®] of California's internal website for use for training and implementation, and the company's external website for access and use by providers.

ValueOptions[®] of California's clinical criteria address all levels of behavioral health care and are designed to facilitate continuity of care throughout the course of service delivery. To ensure that the criteria reflect the latest developments in serving individuals with psychiatric and substance abuse disorders, educational material from professional, consumer, and family member organizations such as the following are reviewed:

- American Psychiatric Association;
- American Psychological Association;
- American Academy of Psychiatrists in Alcoholism and Addictions;
- American Academy of Child and Adolescent Psychiatry;
- American Society of Addiction Medicine;
- TRICare
- Consumer and family empowerment organizations (e.g., state-based Consumer Councils; National Mental Health Consumers' Self-Help Clearinghouse; National Alliance for the Mentally Ill; Federation of Families for Children's Mental Health);
- International Association of Psychosocial Rehabilitation Services;
- InterQual;
- Texas Administrative Code, Subchapter HH regarding Standards for Reasonable Cost Control & Utilization Review for Chemical Dependency Treatment Centers
- The National Institutes of Health;
- The National Institute on Alcohol Abuse and Alcoholism;
- The National Institutes of Drug Abuse;
- Department of Health and Human Services' Center for Substance Abuse Treatment;
- Standard psychiatric texts; and
- Current publications in professional journals and books.