Intensive In-Home Service
May 11, 2016
Pre-Review Checklist

- Are there immediate health/safety concerns? If so, refer to medical staff.
- Does request meet expedited criteria (i.e., health and safety issues)?

**UTP**

- Does start date precede submission date?
- Does request overlap an existing authorization?
- Was SAR submitted more than 30 days before requested start date?
- Was SAR submitted with ICD-10 codes?
Administrative Denials

- Is PCP present and includes IIH frequency and provider?
- Does PCP have a signed service order and written date by approved signatory as well as other required signatures?
- Is a completed and up to date Comprehensive Crisis Plan present?
- Is a CCA and/or addendum present that supports request for IIH and includes CALOCUS, CANS or ASAM scores as appropriate?
Other Items of Review

- Are there “stacked” services? If requested service is an exclusion to a currently authorized service(s), review under EPSDT criteria.
- Is consumer a Medicaid client and under age 21? If so, review for EPSDT.
- Is there an active discharge plan in place?
- Have there been past denials or partial approvals of requested service?
- Are the requested dates/units within the MCO guidelines (current benefit plan)?
- What is the length of stay in current service?
Other Items of Review Continued...

- For concurrent requests, how many face to face contacts with a licensed clinician are documented?
- Has previously requested documentation been submitted?
- Is there evidence of use/intended use of Evidence Based Practices?
- If DSS/DJJ are involved, has a tag been created in Alpha?
- If the request is state funded, is the request accurate based on the current State Funded Benefit Plan?
Intensive In-Home (IIH) Service is:

IIH is a team approach to address the identified needs of children/adolescents who, due to serious and chronic symptoms of an emotional, behavioral or substance use (SU) disorder, are unable to maintain stability in the community without intensive intervention. **IIH is a time-limited, intensive child and family intervention.**

- IIH operates 24/7/365.
- IIH providers are **first responders** for crisis situations.
- IIH is predominately home-based.
IIH Services are intended to:

Accomplish the following:

- Reduce presenting psychiatric or substance use disorder symptoms;
- Provide *first responder* intervention to diffuse any crises that occur 24/7/365;
- Ensure linkage to community services and resources;
- Prevent Out-Of-Home placement for the beneficiary.
What Else?

- Only **one** child in a family can receive IIH at a time
- Parent/caregiver **must be** an active participant in treatment;
- Team Lead or licensed clinician **must** provide direct clinical interventions with each beneficiary;
- IIH Team is responsible for convening a Child/Family Team for person-centered planning;
- Team Lead directs all clinical interventions
- IIH is not delivered in a group setting;
- IIH is face-to-face and primarily a community-based service rather than an office-based service
- IIH teams that serve consumers with substance use issues must have staff who possess a LCAS or CSAC.
- Sex Offender Specific Evaluation (SOSE) must be provided by a trained professional; the SOSE must indicate level of risk.
IIH Interventions

- Individual and Family Therapy
- Substance use disorder treatment
- Development/Implementation of a home-based behavioral support plan with youth and caregivers
- Psychoeducational information about diagnosis, condition, treatment with youth and any individuals involved with care.
- Case Management: assessment, planning, referral and linkage to paid and natural supports
- Monitoring and follow up
- Arranging psychological and psychiatric evaluations
- Consults with medical /non-medical providers (School, DSS DJJ)
- Crisis Management
Who is eligible?

- Consumers from ages 3 through 20 years for Medicaid and ages 3 through 17 for State funding and
- CALOCUS score of 4 with State funding; 3-5 with Medicaid funding for those consumer with a mental health diagnosis; and
- ASAM of 1.3 and greater with State funding and 1-2.1 with Medicaid funding for consumers with a substance use diagnosis; and
- Effective May 1, 2016, consumers ages 3 up to 6 will require the Child, Adolescent Needs Screening (CANS); consumers ages 6 through 17 require CALOCUS and/or ASAM; and
- MH/SA diagnosis per DSM-5 other than a sole diagnosis of developmental disability*; and
- IIH is indicated in a Comprehensive Clinical Assessment (CCA); and
- Outpatient services were considered or previously attempted but found to inappropriate or not effective* and
Continued Eligibility Requirements

- Current/past history of symptoms or behaviors indicating the need for crisis intervention: suicidal or homicidal behaviors, physical aggression toward others, self-injurious behaviors, serious risk taking as evidenced by running away, sexual aggression, sexually reactive behavior or substance abuse; and

- Symptoms and behaviors are unmanageable at home, school or community setting due to youth’s mental health or substance use disorder and intensive and coordinated clinical intervention is required; and
Additional Eligibility Requirements

- Youth is at imminent risk of out-of-home placement* based on mental health or substance use disorder clinical symptomatology or the youth is current in an out-of-home placement and a return home is imminent and
- There is no evidence that alternative intervention would be equally or more effective based on NC community practice standards: Best Practice Guidelines of American Academy of Child and Adolescent Psychiatry, American Psychiatric Association and American Society of Addiction Medicine.*
Questions?
Continuing Care Criteria:

- PCP goals were achieved; additional goals are indicated by documentation of current symptoms or

- Satisfactory progress toward goals; documentation supports continued gains or

- Some progress is evident but PCP needs modifications to allow for greater gains or

- There is no progress or there is regression: diagnosis should be reassessed to identify co-occurring disorders and treatment interventions should be revised based on findings as well as the recommendation of additional or alternative services.
Discharge Criteria:

Any one of the following apply:

- Goals have been achieved; no need of IIH services
- Level of functioning has improved and there is a transition plan to a lower level of care
- No progress or regression occurs in response to IIH and there is a need for more intensive services
- Service is no longer desired
- Failure to show improvement; a different best practice treatment modality is required.
Other IIH Requirements:

- IIH Team to Family ratio must not exceed 1:8
- At least 60% of the contacts occur face-to-face with the youth/caregivers in the home or community.
- Telephone and collateral contacts can be up to 40%.
- 60% of the service must occur outside the provider facility.
- Minimum of 12 contract are required during the first month; at least six (6) contacts during each additional month.
- Only one child per family can be authorized to receive this service at the same time. This does not preclude participation in family therapy.
- The parent/caregiver must be an active participant in the treatment.*
- The billing unit is one unit of at least two (2) hours duration per day by one or a combination of staff of billable activity. *
IIH and Care Management:

- A Service Order which is signed/dated prior to the date of service required.
- Authorization must be obtained prior to service delivery.
- Initial authorization is 60 days-36 units for Medicaid and 32 units for State funding.*
- Continuing authorization is 60 days-36 units for Medicaid and 14 units for State funding. State funding is a hard limit of four(4) months.*
- UM has 14 days from submission of request for authorization to review and make a decision regarding your request-submit at least 10 days prior to the end day of the previous authorization.
- Required documentation includes a PCP, LOC documentation, CCA and Comprehensive Crisis Plan for the initial request.
- For subsequent requests, an updated PCP with progress in outcomes or what interventions you used to address lack of progress is expected with subsequent requests.
IIH Service Exclusions/Limitations

NOT Billable:
- Transportation
- Any habilitation activities
- Social or recreational activities
- Clinical and administrative staff supervision or meetings
- Ongoing monitoring during school
- Ongoing monitoring during other treatment activities
Excluded Services Unless EPSDT

- Multi-Systemic Therapy
- Day Treatment
- Individual Group and Family Therapy
- Substance Abuse Intensive Outpatient Program
- Psychiatric Residential Treatment Facility
- Substance Abuse Residential Services
Expected Outcomes

- Decrease psychiatric/substance use symptoms;
- Reduce frequency/intensity of crisis situations;
- Engagement in the recovery process (youth and caregiver);
- Improved functioning in all settings: home, school and community;
- Youth/caregiver able to identify/manage trigger, cues and symptoms;
- Sustained improvement in developmentally appropriate life domains;
- Increased utilization of coping/social skills that address life stressors resulting from MH/SA or SU condition;
Expected Outcomes cont’d

- Improve conditions of daily living
- Decrease delinquent behaviors when present
- Increased use of available natural and social support by linking youth and caregivers resources
- Prevent out of home placement
- Prevent higher levels of care

IIH is a service that endeavors to identify youth and caregiver strengths and utilize those strengths to enhance opportunities for resiliency and recovery.
Questions?
MH/SU Diagnosis other than a sole diagnosis of IDD:

- If the consumer has an IDD diagnosis, are the behaviors/symptoms part of the IDD diagnosis or is there a MH/SU diagnosis?
- The diagnosis needs to be clearly supported per DSM-5;
- Please refer for a psychiatric or psychological assessment if there is a question of the diagnosis—the earlier the better;
- IIH needs to practice within the team’s scope of practice for each child.
Obtaining Authorization II

Previous Treatment:

- Prior to initiating IIH treatment, there needs to be supporting evidence that outpatient treatment has been attempted;
- You want to know where, when, with whom, how long the child/family received outpatient services;
- What modality did the outpatient provider use?
- What barriers interfered with the success of outpatient treatment?
- Was Home-Based considered?
- Transportation alone is not a factor to support IIH versus outpatient therapy.
Obtaining Authorization III

Comprehensive Clinical Assessment:

- Supports a diagnosis.
- Recommends the service that is most appropriate for the consumer.
- Needs to include important information about the family’s situation-homelessness, lack of adequate food, family MH or SU, domestic violence, physical or emotional abuse, past trauma.
- CCA also includes a family history, history of symptoms and developmental history. It should also identify those who live in and outside of the household and the relationship to the child. The CCA should identify who will be involved in the child’s treatment.
Obtaining Authorization IV

Person Centered Planning (PCP):

- PCP needs to reflect family and youth’s input.
- Significant family members who do not live in the household can be included.
- PCP identifies what the family/child wants/needs to address.
- PCP Goals need to be measurable, attainable and reflect how/what family/child actions will be to achieve goals.
- PCP should be updated and adjusted to address the progress or lack of progress toward goals.
Questions?
Goals

- Articulate what consumer/parent expect as outcome of IIH treatment. For example, “I want to be able to talk to my mother when I am upset without hitting and tearing things up over the next 3 months.”

- Interventions are the means of obtaining the goals. For example, “With therapist, Jan will verbalize 3-4 barriers to staying calm when talking to her mother and explore ways to address each barrier.

- Indicate how the goal will be measured. Progress or lack of progress is evidenced by.....

- Goals need to be positive in outcome. For example, “John will learn and demonstrate ___skills to deal with anger” rather than “John will not be aggressive 5 out of 7 times.”

- Make sure use of evidence based practices is reflected in goals.
Best or Evidence Based Practices

Make sure that the EBP applies to the age group:

- Cognitive Behavioral Therapy (CBT);
- Trauma-Focused Therapy: Seeking Safety, Trauma-Focused CBT, Real Life Heroes;
- Family Therapy (FT): Brief Strategic, Multidimensional Family Behavior, Child Parent or Family Centered Treatment (FCT);
- Motivational Interviewing;
- Person Centered Training;
- System of Care Training

Two Websites for autism: [www.autismspeaks.org](http://www.autismspeaks.org) and [www.autisminternetmodules.org](http://www.autisminternetmodules.org)
When requesting concurrent authorization...

- Consult with supervisor, psychiatrist to address lack of progress.
- If medication is indicated for the diagnosis, address its use and/or reasons for not using. Please refer to “Psychiatric Medications Used for Children and Adolescents” at [http://www.medlineplus.gov](http://www.medlineplus.gov) (in the ‘Drugs and Supplements’ section) and/or Straight Talk About Psychiatric Medications for Kids (Revised Edition) by Timothy E. Wilens, MD.
- Update goals and/or interventions when goals are achieved or when there is no progress toward goals. *Goal is on-going is not sufficient to measure progress.*
- Interventions need to reflect the changing needs of the consumer/family.
- Update treatment plans.
- If you are using screening or assessment tools to measure progress, identify and report outcomes at updates.
Screening tools and rating scales can be used to help measure mental health symptoms and/or measure progress after interventions are put into place.

Symptoms addressed in the table below include anxiety, social anxiety, obsessive-compulsive symptoms, depression, Bi-polar/mania symptoms, suicide risk symptoms, ADHD, Pervasive Developmental DO symptoms, autism, non-verbal LD symptoms and disruptive behavior symptoms.

Please refer to the “Table of All Screening Tools and Rating Scales” at:

http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp.
Cautions:

Use of the screening tools and rating scales does not produce a diagnosis. Rather, the tools and scales point toward the types of mental health disorders that may be worthwhile to consider as a cause of a child’s or adolescent’s emotional or behavioral difficulties.

A particular “score” does not mean that a child has a particular disorder. These screening tools and rating scales are only one component of an evaluation.

Diagnoses should be made only by a trained clinician after a thorough evaluation.

Symptoms suggestive of suicidal or harmful behaviors warrant immediate attention by a trained clinician.
Questions?
Special Review Team Results-Notes

- Full service note must be present for each billed event to include: Name, MID #, Record # and Service Provided, Date of Service, Place of Service, Type of Contact (face to face, telephone, collateral), Who was present, Purpose of Contact, Description of Interventions, Duration of Contact, Description of Effectiveness of Intervention as applies to PCP Goals and Signature and credentials of the staff members who provided the service.

- Note content must support two (2) hours of billable service and should reflect the actual duration of the contact which may be over 2 hours. There must be a note to support each claim.

- Documentation needs to support intensive, individualized services are being provided.

- Documentation supports IIH team is available 24/7 for crisis intervention.
There are few collateral contacts: psychiatric or medical consultation, psychological testing or collaboration with school, employment, DSS, DJJ, Care Coordination, SOC etc. *

There is little evidence of family involvement in the PCP goals/interventions and in the contact notes.

PCP needs to be specific to each youth/family and specifically identify interventions used and response in progress updates.

The Team Lead is responsible for providing individual and family therapy.

Few behavioral plans when most recipients have significant behaviors.

Lack of success at a lower level of care is frequently not met.

Imminent risk of out of home frequently not met. *

Staff without SU licensure or certification treating youth with SU issues.*

Minimal psycho-education offered to youth and families; this is an opportunity to educate the family about the youth’s diagnosis and treatment.
Questions?
Common Goals: Providers & Partners

- Effective, efficient treatment of youth/families with Intensive In-Home services
- Assistance with identifying supports, service resources and service gaps in the catchment area that are available or needed for youth/families.
- Be proactive, send updated information as to how you are going to or have intervened when the youth/family is not progressing. This supports continued care.
- Training and educational opportunities that promote best practices.
- Discharge Planning-referral to services post IIH, communicate with Care Coordination if involved and make sure that the consumer is attached to services.
In Conclusion

Final thoughts or Questions?
Contact Information

Partners BHM: 1-877-864-1454

- **MH/SA UM**: ext. 6434; 1-704-842-6434
- **IDD UM**: ext. 2605; 1-704-884-2605
- **UM Appeals**: ext. 2650; 1-704-884-2650