



PROVIDER ALERT



Alert #3 – 2008 – 2-03 – HCNC

Notification Regarding BHRS Brief Treatment Services for Providers of Child and Adolescent Behavioral Health Services

Community Care will begin to allow NC BHRS providers to implement the Brief Treatment Model of BHRS in all North Central Counties effective on 3/1/08. Please refer to the attached description of the BHRS Brief Treatment Model for further instruction. Please forward this information to all of your child and adolescent service providers/programs.

**The BHRS Brief Treatment Model
(For professional services only, i.e., MT or BSC without TSS)**

The BHRS Brief Treatment Model, including Mobile Therapy (MT) or Behavioral Specialist Consultation (BSC) only, is intended to provide members meeting Medical Necessity Criteria for low level BHRS (BHRS MNC level 1 and 2) with one of these services in a more expedient manner than traditional BHR services, hence the title, “brief (admittance into) treatment”. The goals for this model include;

1. The ability of MT or BSC services to start immediately after a member is discharged from an RTF, inpatient unit, partial hospital program or Family-based Mental Health Services.
2. Maintaining continuity of care via the MT or BSC service being provided by the same therapist when full BHRS services are no longer indicated due to the member’s progress.
3. The ability of MT or BSC service to continue to support the member’s treatment plan when the intensity of Family Based Mental Health Services are no longer necessary, but community based therapeutic interventions will provide substantial benefit.
4. Quick and easy access to BHRS when the member is in need of a step up in service from outpatient but not in need of full BHRS. Examples include;
 - a. The use of MT or BSC for members and families who have difficulty generalizing therapeutic skills from a clinic based setting to the natural environment.
 - b. Provision of therapeutic services in the community for members and families who have difficulty maintaining clinic based appointments due to transportation, childcare or other problems that impede attendance.
5. Providing members a way to access further assessment, if needed, by a master’s level clinician in the field. Examples include;
 - a. Provision of community based therapeutic services for children who have difficulty leaving their home environment due to their symptomatology, i.e., depression, school phobia, OCD, agoraphobia and autism, for example.
 - b. Provision of community based therapeutic interventions for children who are resistant to attend clinic based programs, i.e., members with ODD, conduct disorder and/or substance abuse, for example.
6. Expanding the role of the MT (in BHRS Brief Treatment and Traditional BHR Services) to include behavioral health consultation and collateral therapy.
 - a. The MT can provide behavioral treatment for a child pending that all of the following criteria are met:
 1. The person providing MT services has the behavioral expertise to conduct such treatment
 2. The child’s symptoms/behavior require behavioral intervention as outlined in the treatment plan
 3. BSC is not prescribed/authorized for the child
 - b. Behavioral interventions and collateral therapy performed and billed as MT may include:
 1. Consultation with parents, school officials, and other persons either in person or by phone concerning the behavioral health needs of the child
 2. Attendance at meetings involving the child’s behavioral health issues
 3. Phone calls to the child or family in times of crisis; however, please note that BHRS is not a mobile or phone crisis service and a crisis plan utilizing appropriate crisis services should be developed with the child/family/caretakers
 4. Development of the treatment plan goals and objectives
 5. Collecting and analyzing data for the purpose of developing a behavior plan
 6. Designing, developing and directing the implementation of an individualized behavior management plan, which is separate and distinct from the comprehensive treatment plan
 7. Assessment and Assistance for new TSS (which is billed as Assessment and Assistance, not MT)
 8. Provision of collateral therapy to other members in the home (e.g., collateral therapy is therapy, which is related to the primary consumer)

7. Permitting continuity of care for the member/family by:
 - a. Maintaining the child/family with the current clinician (MT *or* BSC) and continuing the therapeutic alliance rather than being discharged to an outpatient level of care; which requires a change in clinician and the development of a new therapeutic alliance, which may result in the loss of skills and/or the deceleration of treatment progress.
 - b. Allowing for “booster shot treatment”, i.e., the provision of up to three non-consecutive, two-week booster sessions as needed for stabilization of the child/family within one year after the service has ended. Booster sessions are limited to a maximum of MT *or* BSC for up to 6 hours/week and must be pre-authorized by the BHRS Care Manager.

BHRS Brief Treatment Guidelines:

- An evaluation/assessment from a behavioral health provider *and* a Prescriber Collaboration Form for BHRS Brief Treatment by a psychiatrist or licensed psychologist will be used to establish Medical Necessity for this service.
- All medical necessity determinations will be based upon DPW’s Appendix T BHRS Medical Necessity Criteria (severity level I and II are most appropriate).
- Treatment is limited to MT *or* BSC *only*. A member will receive either MT *or* BSC, but not both services at the same time. TSS services will not be provided during BHRS Brief Treatment.
- Brief Treatment will be limited to a maximum of seventy-two (72) consecutive weeks of service (up to 2 consecutive 36-week episodes of care).
- Treatment will be limited to a minimum of 1 hour per week and a maximum of six hours per week.
- Treatment delivery will begin with a specific number of hours/week (1 – 6 hrs/week) as recommended by the licensed psychologist or psychiatrist, but the prescription may be changed (as long as the proposed hours are between 1 – 6 per week) dependent on the child/family’s need, concurrent review and agreement of the ISPT members, including the licensed psychologist or psychiatrist, with the plan for service.
- Three, non-consecutive two-week booster sessions will be permitted as needed for stabilization of the child/family within one year after the BHRS Brief Treatment service has ended. Booster sessions are limited to a maximum of MT *or* BSC for 6 hour/week. If more than two weeks of booster treatment is needed to stabilize the child, an additional booster session or a referral for Brief Treatment, Traditional BHRS or another appropriate level of care will be made.

Pre-authorization Process for BHRS Brief Treatment:

1. An Evaluation or assessment must be completed by a Master’s level or higher-level clinician (Ph.D., M.D.) and must include all of the following;
 - Referral concerns (please include description of symptoms including frequency, severity, and domains in which symptoms are occurring)
 - Mental Illness/Substance Abuse (MISA) Screen (**outline can be found in the 6-6-02 Provider Alert, which is attached for your review**)
 - Abuse and domestic violence Screen
 - Current psychotropic medication (name, dosage, schedule, reason and prescriber)
 - 5 axis diagnosis
 - Recommendation that outpatient behavioral health treatment is inappropriate or insufficient to meet the needs of the child
 - The prescriber sign-off via the prescriber collaboration form (which must be completed within **60 days** of the evaluation/assessment date)
2. ISPT Meeting – including the family, member, BHRS clinician, school (if services are to occur within the school) and any other already established behavioral health service or service system provider to;
 - Develop treatment plan
 - Discuss number of service hours needed
 - Complete family choice notification
 - Complete ISPT sign-in sheet
 - Complete ISPT Summary

3. Prescriber collaboration/prescription
 - Prescriber (licensed psychologist or psychiatrist) reviews evaluation/assessment and ISPT summary
 - Prescriber indicates agreement or disagreement with the service and number of hours recommended
 - Prescriber identifies any change in the number of hours if in disagreement with the ISPT recommendation
 - Prescriber must always sign the collaboration form (even if in agreement with the ISPT recommendations) as this will suffice as the prescription.

Initial Authorization Process

1. Provider submits the following items within 5 business days from the date of the ISPT to Community Care to request an initial authorization for BHRS Brief Treatment;
 - The POC – indicating Brief Treatment; type of service and number of hours/units (between 1 – 6 hrs for up to 24 weeks of treatment)
 - A copy of the evaluation/assessment
 - The family choice notification form
 - The ISPT sign-in sheet; summary *and* Prescriber Collaboration Form
2. The treatment plan is due to Community Care within 5 weeks from date of the verbal authorization for BHRS Brief Treatment services

Continued Stay Review Process

1. An ISPT is held in the 19th or 20th week of Brief Treatment
2. The following items are submitted to Community Care 2 weeks (14 days) prior to the end of the current authorization period;
 - The POC – indicating Brief Treatment; type of service and number of hours/units (between 1- 6 hrs for up to 12 weeks of treatment)
 - The ISPT sign-in sheet; summary *and* Prescriber Collaboration
 - An updated tx plan

If a Second 36-Week Episode of Brief Treatment is Needed

Community Care will allow up to 2 consecutive episodes of Brief Treatment if a child meets MNC for this service, i.e., Level 1 or 2 MNC for BHRS. Please follow these steps if a second episode of Brief Treatment is needed:

1. A Master's level or higher-level clinician completes an assessment/evaluation within **45 days** of the expiration date of the current service period.
2. An ISPT is held in the 32nd or 33rd week of Brief Treatment
3. The following items are submitted to Community Care 2 weeks prior to the end of the current authorization period;
 - The assessment/evaluation
 - The POC – indicating Brief Tx; type of service and number of hours/units (between 1 – 6 hrs and up to 24 weeks of treatment)
 - The ISPT sign-in sheet; summary and Prescriber Collaboration
 - An updated tx plan

Continued Stay Review Process

1. An ISPT is held in the 55th or 56th week of Brief Treatment.
2. The following items are submitted to Community Care 2 weeks prior to the end of the current authorization period;
 - The POC – indicating Brief Tx; type of service and number of hours/units (between 1 – 6 hrs and up to 12 weeks of treatment)
 - The ISPT sign-in sheet; summary and Prescriber Collaboration
 - An updated tx plan

Request for Authorizations for Booster Sessions

Up to three non-consecutive, two-week booster sessions may be requested as needed for stabilization of the child/family within one year after the service has ended. Booster sessions are limited to a maximum of MT *or* BSC for 6 hour/week and must be pre-authorized by the BHRS Care Manager via the provider submitting a POC indicating Booster Session, type of service and number of hours up (between 1 – 6 hrs for up to 2 weeks of treatment)

BHRS Reporting Requirements for BHRS Brief Treatment

Providers are required to report MT *or* BSC Brief Treatment services via the Monthly BHRS Reporting Requirements. Report Brief Treatment services as follows;

- Date Services First Requested = the date of eval/asst requesting brief treatment
- Date of Evaluation in which BHRS Service First Prescribed = the date prescriber signed the collaboration form
- Date Service First Offered or Provided as Authorized = the date the Brief Treatment service commenced (e.g., commencement = the first day of the week in which all authorized services were delivered as authorized)

Discharge Process

The Community Care BHRS Discharge Summary, which is also used for Traditional BHR Services, will be required when BHRS Brief Treatment Services are discontinued (unless the child is being transferred to Traditional BHR services). Please use the following process:

- No BHRS Discharge Summary if the child is being transferred to Traditional BHR Services.
- The BHRS Discharge Summary can be found on the Community Care Website at <http://www.ccbh.com/providers/phealthchoices/forms/index.php>
- The BHRS Discharge Summary is HIPAA compliant and is to be completed (information typed into the summary) by the provider and e-mailed to the assigned Care Manager within 2 weeks of the member's discharge from BHRS Brief Treatment Services.
- Providers are expected to give the Care Manager verbal notification on or before the actual discharge date.
- The child's discharge caregiver's name, address and phone number must be faxed or left on your care manager's voice mail to complete the discharge summary process.

*Please note that if a child has been discharged from BHRS for 30 or more consecutive days and BHRS (Brief Treatment or Traditional BHR services) are recommended, this is a new initial BHRS packet. BHRS reporting is required for all new BHRS services.

** Please note that if Brief Treatment services are not meeting the behavioral health needs of the member a referral to traditional BHRS or another level of care is possible at any time during the Brief Treatment process. Please note that a full Best Practice is required if traditional BHR services are being recommended.



PROVIDER ALERT

HealthChoices Allegheny

Alert # 3-2002-06-06 A

SCREENING FOR CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS (MISA)

EFFECTIVE IMMEDIATELY

In 1999, the MISA Consortium, comprised of a small group of stakeholders from the Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) and the Department of Health's Bureau of Drug and Alcohol Programs (BDAP), released initial recommendations for services to persons with co-occurring mental illness and substance abuse disorders. The report of the MISA Consortium emphasized the fact that early identification of the existence of co-occurring disorders is crucial to ensuring that individuals receive appropriate behavioral health services. The report of the MISA Consortium recommended an initial screening process and identified essential components of a MISA assessment, to be conducted at the point of entry into either the mental health or the drug and alcohol service delivery system.

Community Care is committed to furthering the implementation of the recommendations outlined in the MISA Consortium Report. Therefore, as a beginning point, Community Care is issuing this alert to clearly communicate our expectation that all members requesting behavioral health services be screened for the presence of symptoms of mental health issues and issues related to alcohol and other drug usage. Within the first seven days of contact with a member or no later than the first continuing stay review, providers are expected to screen for the presence of mental health and substance abuse issues. The purpose of the screening process is to assess the member's immediate needs and whether emergency services are warranted. It is also our goal to ensure that all members are screened and then referred for an assessment for co-occurring disorders when indicated.

Consistent with the 1999 MISA Consortium Report, the MISA screening process is to be conducted by appropriately trained individuals and is to identify:

- 1) Alcohol and other drug issues
 - a) Substances used and intensity of use
 - b) Likelihood and severity of withdrawal
 - c) Medical and behavioral risk secondary to intoxication
- 2) Mental health issues
 - a) Suicidal, homicidal ideation/intentions/plans/history
 - b) Impairment of function and/or judgment
- 3) Medical issues
 - a) Pregnancy
 - b) Conditions posing an immediate risk of harm to self or others
 - c) Current medications and recent ingestions of any non-prescribed drugs or alcohol
- 4) Special needs
 - a) Barriers to access
 - b) Environmental risks

When contacting Community Care to request an initial authorization for services for a member, the care manager will ask if you have conducted a MISA screening of the member in question. All providers are expected to screen for the need for mental health services **and** drug and alcohol services for each individual that approaches them for treatment and to assist the member in accessing necessary services. Providers are also expected to re-assess for the existence of co-occurring disorders all those individuals that continue to receive services on at least an annual basis. Please be aware that Community Care's care managers will inquire as to whether such assessments have occurred and will prompt you to complete a MISA screening when appropriate.

When conducting routine medical chart audits, Community Care will determine provider compliance with this expectation for all levels of care. In addition, at site visits by our Credentialing Department, Community Care will ask for verification that providers have a policy and procedure in place that demonstrates the provider's commitment to assess all of the individuals they serve for mental health and substance abuse issues.

Community Care will offer several training sessions for providers in the near future. The training sessions will provide instruction as to how to conduct the screening process and will further discuss this expectation as it relates to our overall goal of improving the identification of members in need of treatment to address co-occurring disorders and ensuring that members are linked appropriately to needed services. Providers are expected to send at least one lead clinician to a training session. Providers are expected to then share the information from the training with appropriate staff within their organization to ensure that individuals are adequately trained to screen for the possibility of co-occurring disorders.