Florida Medicaid Supplemental Clinical Criteria

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Table of Contents **Page**

Introduction & Instructions for Use

Introduction

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 Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. 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.

Instructions for Use

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.

Applied Behavior Analysis

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

General Admission Criteria

- Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:
    - Safety - aggression, self-injury, property destruction, elopement
    - Communication - problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
    - Self-stimulating – abnormal, inflexible, or intense preoccupations
    - Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
    - Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables
- The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:
    - Primary care physician with family practice, internal medicine, or pediatrics specialty
    - Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
    - Child psychologist
- The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.
- Services must be rendered by one of the following:
    - Lead Analysts who are one of the following:
        - Board certified behavior analyst (BCBA) credentialed by the Behavior Analyst Certification Board®
        - Florida certified behavior analyst (FL-CBA) credentialed by the Behavior Analyst Certification Board®
        - Practitioner fully licensed in accordance with Chapters 490 or 491, F.S., performing within their scope of practice
    - Board certified assistant behavior analysts (BCaBA) credentialed by the Behavior Analyst Certification Board® working under the supervision of a BCBA
    - Registered behavior technicians (RBT) credentialed by the Behavior Analyst Certification Board® working under the supervision of a BCBA or BCaBA

Specific Admission Criteria

Behavior Assessment and Behavior Plan

- A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.
- The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:
- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

- The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.
- The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.
- The behavior plan must reflect the requested authorization period (up to six months).
- A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.
- More frequent assessments must be conducted when:
- New behavior emerges that interferes with a recipient's participation in a major life activity
- Additional BA services are medically necessary and are likely to address the emergent behavior
- A full assessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

Behavior Analysis Interventions

- Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must document the reasons for nonparticipation. Documentation should also explain potential impacts of nonparticipation and how potential impacts are being mitigated. Services include:
- Adaptive behavior treatment by protocol – behavior analysis services provided according to the authorized treatment protocol
    - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
    - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
    - Maximum group size is six recipients
    - Services may be provided by Lead Analyst, BCaBA, or RBT
    - Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress Maximum group size is six recipients
    - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
    - The recipient may or may not be present depending upon clinical appropriateness
    - Services may be provided by Lead Analyst or BCaBA
    - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

Supervision

- Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan.

Early and Periodic Screening, Diagnosis, and Treatment

- As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

Discharge Criteria

- Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:
- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level of functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment.

Exclusion Criteria

- Services related to this policy are not covered when any of the following apply:
- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service
- Any procedure or physical crisis management technique that involves the use of seclusion or manual, mechanical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services*
- Services on the same day as therapeutic behavioral on-site services*
- Services on the same day as therapeutic group care services*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

Documentation Criteria

- For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.
- Original referral documentation must be maintained in the recipient's medical record.
- The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:
- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
    - Definition in observable, measurable terms
    - Direct observation and measurement procedures
    - Current level (baseline)
    - Behavior reduction or acquisition procedures
    - Condition(s) under which behavior is to be demonstrated and mastery criteria
    - Date of introduction

    - Estimated date of mastery
    - Plan for generalization
    - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
    - Proposed targets, goals, and objectives (as above)
    - Training procedures
    - Date of introduction
    - Estimated date of mastery
- Number of units requested
    - Number of units for each billing code
    - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan
- Crisis management plan
- Discharge plan

Continuation of Services

- In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:
- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested.
- If significant clinical progress is not made over the course of an authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.
- Session notes must be signed and dated by the rendering practitioner. Session notes must include:
- Date, time, location, and duration of services
- Maladaptive behaviors observed during the session
- The replacement/compensatory skills targeted during the session
- Description of the recipient's response to the treatment interventions
- Protocol modification, changes to goals/objectives, and/or therapist directions provided during the session, if included
- Explanation if recipient's parent or guardian is not present during BA service delivery
- Participants, including observers, teachers, parents, caregivers, or other health care providers if present
- Providers must maintain confidentiality of other recipients receiving services in a group setting

Billing/Reimbursement Guidance

Behavior Analysis Fee Schedule – January 1, 2025

Service Description	Procedure Code	Modifier	Reimbursement / Service Limitation	Maximum Fee
Behavior identification - assessment	97151		Max 24 units per behavior assessment	$19.05 per 15 minutes
Behavior identification - supporting assessment	97152		Max 8 units per behavior assessment	$12.19 per 15 minutes
Assessment add-on practitioner	0362T		Max 16 units for initial or reassessment; prior auth required	$12.19 per 15 minutes
Behavior Reassessment	97151	TS	Max 18 units for reassessment	$19.05 per 15 minutes
Behavior treatment with protocol modification (Lead Analyst)	97155			$19.17 per 15 minutes
Behavior treatment with protocol modification (Assistant)	97155	HN		$15.37 per 15 minutes
Behavior treatment with protocol modification (Concurrent supervision)	97155	XP	Not reimbursed	Not reimbursed
Behavior treatment by protocol	97153			$12.26 per 15 minutes
Behavior treatment by protocol (Concurrent supervision)	97153	XP	Not reimbursed	Not reimbursed
Treatment add-on practitioner	0373T		Prior auth required	$12.19 per 15 minutes
Family training by Lead Analyst	97156			$19.05 per 15 minutes
Family training via telemedicine	97156	GT	Up to 2 hours/week	$19.05 per 15 minutes
Family training by assistant	97156	HN		$15.24 per 15 minutes
Group BA protocol (2 clients)	97154	UN		$7.58 per 15 minutes
Group BA protocol (3 clients)	97154	UP		$7.08 per 15 minutes
Group BA protocol (4 clients)	97154	UQ		$6.58 per 15 minutes
Group BA protocol (5 clients)	97154	UR		$6.08 per 15 minutes
Group BA protocol (6 clients)	97154	US		$5.58 per 15 minutes
Group BA protocol mod (2 clients)	97158	UN		$9.58 per 15 minutes
Group BA protocol mod (3 clients)	97158	UP		$9.08 per 15 minutes
Group BA protocol mod (4 clients)	97158	UQ		$8.58 per 15 minutes

Group BA protocol mod (5 clients)	97158	UR		$8.08 per 15 minutes
Group BA protocol mod (6 clients)	97158	US		$7.58 per 15 minutes

NOTE: One BA practitioner's services are reimbursable when concurrent services are provided by more than one BA practitioner, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan.

Clubhouse

Clubhouse services provide structured, community-based services delivered in a group setting that utilize behavioral, cognitive, or supportive interventions to improve a recipient's potential for establishing and maintaining social relationships and obtaining occupational or educational achievements. Clubhouse services consist of social, educational, pre-vocational and transitional employment rehabilitation utilized to assist the recipient with the following:

- Eliminating functional, interpersonal, and environmental barriers
- Restoring social skills for independent living and effective life management
- Facilitating cognitive and socialization skills necessary for functioning in a work environment

Clubhouse services are rehabilitative and utilize a wellness model to restore independent living skills. They must be delivered in a group setting that cannot exceed 12. Florida Medicaid recipients must be at least 16 years old to receive Clubhouse services.

Admission Criteria

- The member has a mental health diagnosis; and
- The member is at least 16 years of age; and
- Services are provided by one of the following qualified professionals: Physician, Psychiatrist, PPA, Psychiatric ARNP, LPHA, Master's level CAP, Master's level practitioner, CAP, Bachelor's level practitioner, Certified recovery peer specialist, Certified psychiatric rehabilitation practitioner, Certified recovery support specialist, or Certified behavior health technician; and
- Services are provided in a group with a maximum staff to member ratio of 1 to 12; and
- The member exhibits psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, prevocational, and educational functioning.

Service Delivery

- The provider collects information from the member and other sources about the following:
- The member's vocational/educational, social relationship, and independent living goals;
- The member's current psychiatric evaluation.
- The provider and member use the findings of the initial evaluation to develop an activity plan as close to the date the member accessed Clubhouse, but no later than 1 week after accessing Clubhouse.
- Members at their choice are involved in writing the records reflecting their participation in Clubhouse.
- Records are signed by the provider and member.
- The activity plan includes the following:
- The member's vocational/educational, social relationship and independent living goals;
- The skills, knowledge, activities or other interventions that will be used for each goal;
- Activities needed to improve the member's engagement such as motivational enhancement or learning activities;
- The plan to coordinate Clubhouse services with the member's behavioral health provider and other service providers.
- Documentation includes at least a daily progress note that addresses each service provided.
- A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

Psychosocial Rehabilitation

Psychosocial rehabilitation services restore a recipient's skills and abilities necessary for independent living through the following activities:

- Development and maintenance of necessary daily living skills

- Food planning and preparation
- Money management
- Maintenance of the living environment
- Training in appropriate use of community services

Psychosocial rehabilitation services combines daily medication use, independent living and social skills training, housing services, pre-vocational and transitional employment rehabilitation training, social support, and network enhancement to recipients and their families. Psychosocial rehabilitation services must assist the recipient with the following:

- Eliminating or compensating for functional deficits and interpersonal and environmental barriers
- Restoring social skills for independent living and life management

Psychosocial rehabilitation services can include the following to facilitate cognitive and socialization skills necessary for functioning in a work environment and maintaining independence:

- Work readiness assessments
- Job development on behalf of the recipient
- Job matching
- On-the-job training and support

Psychosocial rehabilitation services must concentrate on the amelioration of symptoms and restoring functional capabilities. They can be provided in a facility, home, or community setting. Psychosocial rehabilitation services can be delivered to groups that do not exceed 12

Admission Criteria

- Services must be provided by one of the following qualified professionals: Physician, Psychiatrist, PPA, Psychiatric ARNP, LPHA, Master's level CAP, Master's level practitioner, CAP, Bachelor's level practitioner, Certified recovery peer specialist, Certified psychiatric rehabilitation practitioner, Certified recovery support specialist, Certified behavior health technician, or Substance abuse technician; and
- Services are provided in a group with a maximum staff to member ratio of 1 to 12; and
- The member exhibits psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, prevocational, and educational functioning.

Service Delivery

- Documentation includes at least a daily progress note that addresses each service provided.
- A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

Specialized Therapeutic Foster Care

SPECIALIZED THERAPEUTIC FOSTER CARE services are intensive treatment services provided to members under the age of 21 years with emotional disturbances who reside in state licensed foster homes. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.

The goal of specialized therapeutic foster care is to enable a member to manage and work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.

Specialized therapeutic foster care services incorporate clinical treatment services which are behavioral, psychological, and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster care parent(s), a primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.

There are two levels of specialized therapeutic foster care, which are differentiated by the supervision and training of foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal, age-appropriate activities of members who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the members.

Specialized therapeutic foster care services are offered at Level I and Level II, with crisis intervention available at both levels.

Admission Criteria

- Level I and Level II: General Requirements
- The member is under age 21 and resides in a state licensed foster home; and
- The member has an emotional disturbance; and
- The member does not have a cognitive deficit severe enough to prohibit service from being of benefit to the member
- Level I Requirements
- The member has a history of abuse or neglect, or delinquent behavior and meets at least 1 of the following criteria:
- The member would require admission to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center without specialized therapeutic foster care.
- The member has been admitted to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center within the last 2 years.
- Level II Requirements
- The member meets the criteria for Level I; and
- The member exhibits at least 1 of the following behaviors:
- Destruction of property;
- Physical aggression toward people or animals;
- Self-inflicted injuries;
- Suicidal ideation or gestures;
- An inability to perform activities of daily living and community living due to psychiatric symptoms.
- Level I and II: Crisis Intervention Services
- The member meets the criteria for Level I or Level II; and
- The member is experiencing a behavioral, emotional, or psychiatric crisis which requires stabilization.

Service Delivery

- Prior to development of a treatment plan the provider completes a comprehensive behavioral health assessment of the member's mental health status, substance use concerns, functional capacity, strengths and service needs, or an assessment is already on file and the assessment was conducted within the last 6 months.
- A comprehensive behavioral health assessment must be initiated within 10 working days of crisis intervention services for any member who has not had a comprehensive behavioral health assessment in the past year.
- The comprehensive behavioral health assessment must include at least the following information:
- General identifying information.
- Reason for referral.
- Sources of information (e.g., counselor, hospital, law enforcement).
- Results of interviews and interventions conducted by the assessor;
- Cognitive functioning, screening for emotional-social development, problem solving, communication, response of the child and family to the assessment, and ability to collaborate with the assessor.
- Previous and current medications including psychotropic.
- Last physical examination, including pre-natal, pregnancy and delivery history, and any known medical problems (e.g., prenatal exposure, accidents, injuries, hospitalizations) which may affect the recipient's mental health status.
- History of mental health treatment of the recipient's parents and siblings. The mother's history, including a depression screen, is important in developing this section.
- History of substance use and alcohol or chemical dependency of the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- Emotional status, including a hands-on, interactive assessment of the recipient regarding sensory and regulatory functioning, attention, engagement, constitutional characteristics, and organization and integration of behavior.

- Educational analysis, including daycare issues concerning behavioral and developmental concerns.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- Cultural analysis, including discovery of the family's unique values, ideas, customs and skills that have been passed on to family members and that require consideration in planning and working with the recipient's family. This component includes assessment of the family's own operational style, including habits, characteristics, preferences, roles, and methods of communicating with each other.
- Situational analysis including direct observation of the parent or caregiver's interaction with the recipient in the home, school or childcare setting, work site, and community, whenever the recipient routinely participates in these settings.
- Present level of functioning, including social adjustment and daily living skills.
- Activities catalog, including assessment of activities in which the recipient has interest or enjoys.
- Ecological analysis, including relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family. A relational assessment should be provided to assess any attachment issues the recipient exhibits.
- Assessment of the desired services and goals from the recipient and the recipient's parent or guardian's viewpoint.
- An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.
- For recipients under the age of 4 years, Medicaid recommends use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) for assistance in determining the infant or child's ICD diagnosis.
- For member under age 6 the comprehensive behavioral health assessment should also include completion of a standardized assessment, such as the Child & Adolescent Needs and Strengths an Information Integration Tool for Early Development CANS-0 to 3 Manual (CANS 0-3) and the Florida's Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment 0-5 Manual (CANS 0-5).
- For members aged 6 through 20 years the comprehensive behavioral health assessment should also include completion of a standardized assessment tool, such as the Child & Adolescent Needs & Strengths and Information Integration Tool for Children and Adolescents with Mental Health Challenges CANS-MH Manual (CANS-MH) or the Child and Adolescent Needs and Strengths-(CANS) Comprehensive Multisystem Assessment Manual (CANS-Comprehensive).
- A treatment plan is developed by the primary clinician within the following number of days of admission:
- Level I – 30 calendar days
- Level II – 14 calendar days
- Crisis Intervention – 14 calendar days
- The member's parent or guardian should be included in the development of the individualized treatment plan if the member is under the age of 18 years. Treatment planning for a member under the age of 18 years that does not include the member's parent, guardian, or legal custodian in a situation of exception requires a documented explanation.
- A psychiatrist assigned to the program must interview the member and conduct a formal treatment plan review as follows from the date of authorization of the member's initial treatment plan:
- Level I – quarterly
- Level II – monthly
- Crisis Intervention – monthly
- The multidisciplinary team must re-authorize services no less than every 6 months.

Statewide Inpatient Psychiatric Program

STATEWIDE INPATIENT PSYCHIATRIC PROGRAM (SIPP) services are sub-acute medical and mental health-related services provided by or under the direction of professional or technical personnel, in an institution that is privately owned, licensed as a psychiatric hospital or residential treatment center for children and adolescents, and enrolled as a SIPP provider in the Florida Medicaid program.

SIPP serves high-risk Medicaid members under age 21 who require placement in a psychiatric residential setting due to a primary diagnosis of serious mental illness or emotional disturbance. Members served in SIPP typically require a level of service beyond that which is provided in community-based services or acute inpatient settings.

SIPP is intended to stabilize and adequately resolve presenting problems and symptoms, incorporate permanency, design effective aftercare treatment plans, and ensure coordination with State agencies and community services where applicable with the goals of reducing recidivism and relapse, and reducing the length and frequency of acute inpatient admissions.

Admission Criteria

- The member is under 21 years of age and is eligible under one of the following Medicaid categories:
- TANF-related;
- Supplemental Social Security (SSI);
- SSI-related; and
- Recipients in the care and custody of the state must be assessed in accordance with section 39.407(6)(b), F.S.
- Recipients not in the care and custody of the state must be assessed by a Florida licensed psychologist or psychiatrist, with experience or training in childhood disorders. The assessment must result in a report with written findings as required by the Department of Children and Families in Rule 65E-9.008, F.A.
- A current Diagnostic and Statistical Manual of Mental Disorders or International Classification Diagnosis code
- A description of the initial treatment plan relating to the admitting symptoms
- Current symptoms requiring SIPP treatment
- Medication history
- Prior psychiatric inpatient admissions, if applicable
- Documentation that the recipient is mentally competent, has age appropriate cognitive ability, and is sufficiently able to benefit from cognitive-based treatment
- Documentation of the recipient's physical health, as certified by a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, or other professional who has the authority to perform physical examinations of a medical nature
- Prior alternative treatment
- Medical, social, and family histories
- Proposed placement and community-based treatments after discharge
- Suitability Assessment recommendation (for recipients in the custody of the state)

Treatment Planning & Service Delivery

- Prior to admission, the member's parent or guardian should receive an explanation of why SIPP is being recommended. The explanation should include the nature, purpose and expected length of treatment.
- The treatment plan should:
- An individual plan of care developed and implemented within 14 days after admission in accordance with 42 CFR 441, Subpart G
- Psychiatric or psychological assessment, and diagnosis
- Routine medical and dental treatment
- Clinical and therapy services
- Mandatory family or other caregiver involvement that supports the recipient in meeting treatment goals and returning to the community
- Peer support groups directed toward meeting the recipient's specific treatment goals
- A certified education program provided in accordance with Rule 6A-6.0361, F.A.C.
- Comprehensive discharge (aftercare and follow-up services) planning, developed and implemented in accordance with the SIPP provider's licensure
- Recreational, vocational (for recipients ages 16 and older), and behavior analysis services (when necessary)
- Time out in accordance with 42 CFR 483 (when necessary, regardless of licensure type)
- Seclusion and restraint in accordance with 42 CFR 482 or 42 CFR 483 (when necessary and as appropriate to the provider's licensure type)
- Therapeutic home assignment should be active, individualized, family-centered, culturally sensitive, trauma-informed, and focused on the problems that necessitated SIPP.
- The treatment plan is reviewed within 30 days of admission and monthly thereafter.
- The psychiatrist shall at a minimum:
- Be on call 24 hours a day;
- Interview the member weekly, or more often if medically necessary, to assess progress toward meeting treatment goals;
- Supervise treatment for members who are on psychotropic medications;
- Coordinate care with the member's primary care physician when indicated by the member's medical condition;
- Attend member staffing.
- The provider shall at a minimum deliver:

- One individual session and 1 family therapy session weekly, based on clinical best practices and accepted clinical guidelines, and provided in accordance with the member's individual needs.
    - If the member is unable to participate in 60-minute individual and family therapy sessions, shorter and more frequent sessions should be offered to provide comparable intervention duration.
    - The member's developmental and cognitive style may indicate the need for weekly individual sessions with a behavioral analyst in place of weekly individual therapy.
- Weekly group therapy services.
- Therapeutic home assignments to allow the member and the member's family to practice skills learned in the program.
- Assistance with helping the member and the member's parent learn to manage behaviors in age-appropriate ways.
- The behavioral analyst completes a behavioral review of any of the following:
- Members aged 10 and under, upon admission.
- Members who have an IQ of 69 or less, upon admission.
- Members whose rate of time out is not decreasing in the timeframe anticipated by the treatment team.
    - As used here, time out does not include voluntary time outs that the member requests or initiates in the process of learning and practicing self-management of behavior.
- Members whose behavior has required seclusion or restraint.
- The behavior review shall:
- Identify behaviors contributing to the need for residential treatment so they may be addressed in the treatment plan.
- Identify factors contributing to the need for time out, seclusion and restraint so early intervention measures can be taken.
- Assess the seriousness of the member's behavior and identify trends to determine if additional assessment or a behavior plan is necessary.
- Ensure that the level or point system, if one is used, or other similar method is appropriate and understood by the member.
- The behavioral analyst completes a Comprehensive Behavior Analysis Assessment when any of the following occur:
- A member has been restrained at least 2 times within a 30-day period.
- A member has been in seclusion at least 3 times within a 30-day period.
- A member is referred for assessment by the treatment team.
- The Comprehensive Behavior Analysis Assessment:
- Describes the target behaviors.
- Identifies the events, times and situations when the target behaviors occur.
- Describes the antecedents and consequences controlling the target behaviors.
- Describes the assessment methods.
- Describes the direct observation of the member.
- Displays the data collected in graphic form.
- Summarizes the findings of the assessment and individualized recommendations.
- The behavioral analyst develops a behavior plan in consultation with the treatment team.
- The behavioral analyst trains and monitors staff to implement the interventions and collect data.
- Within 30 calendar days of the planned discharge, the primary therapist contacts the following to coordinate discharge:
- The discharge setting;
- The member's school;
- The receiving treatment provider;
- The Regional Substance Abuse and Mental Health office;
- Other agencies, programs, or community services from which the member will receive assistance.
- Within 1 week prior to discharge, the provider ensures that community supports, and aftercare treatment services are in place.

Targeted Case Management

TARGETED CASE MANAGEMENT (TCM) assists member in gaining access to needed medical, social, educational, and other services.

The primary goal of Targeted Case Management is to optimize the functioning of members who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner.

Targeted Case Management services include working with the member and the member's natural support system to develop and implement the member's service plan. Services also include follow-up to determine the status of services, and the effectiveness of activities related to enhancing the member's inclusion in the community.

NTENSIVE CASE MANAGEMENT (ICM) provides case management to adults who have a serious and persistent mental illness and is intended to assist members with remaining in the community and avoiding institutional care.

Intensive Case Management case managers coordinate needs assessments, service planning, and provide service oversight. In addition, case managers also provide crisis support, and skills training in the member's natural environment including training to promote independent living.

Admission Criteria – TCM Children and Adolescents

- The member is 17 years of age or younger; and
- The member has an emotional disturbance or a serious emotional disturbance; and
- The member is in out-of-home mental health placement or is at documented risk of out-of-home mental health placement; and
- The member is not receiving duplicate case management services except in the following circumstances:
- Optum Behavioral Health refers the member for 30-day certification and the area Medicaid office assigns a different case manager for the purpose of consultation, peer review, and provision of service planning;
- The member's regular case manager is unavailable;
- The member is a transition youth aged 18-22; and
- A member may receive TCM for up to 30 calendar days without meeting the above criteria under either of the following conditions:
- The member has been referred by Optum Behavioral Health after a denied admission to or discharge from an inpatient psychiatric unit.
- The member has been admitted to an inpatient psychiatric unit and has been identified as high risk by Optum Behavioral Health.
- Coverage of TCM is not available beyond the 30-day period unless the member meets the criteria for TCM.

Admission Criteria – TCM Adults

- The member is 18 years of age or older; and
- The member has a Severe and Persistent Mental Illness and based upon professional judgment, the illness will last for at least 1 year; and
- At least one of the following requirements are met:
- The member is awaiting admission to or has been discharged from a state mental health treatment facility.
- The member has been discharged from a mental health residential treatment facility.
- The member has had more than 1 admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months.
- The member is at risk of institutionalization for mental health reasons.
- The member is experiencing long-term or acute episodes of mental impairment that may put the member at risk of requiring more intensive services; and
- The member is not receiving duplicate case management services.
- If the member has relocated from a Department of Children and Families (DCF) district or region where he/she was receiving TCM, the member does not need to meet the above criteria.
- A member may receive TCM for up to 30 calendar days without meeting the above criteria under either of the following conditions:
- The member has been referred by Optum Behavioral Health after a denied admission to or discharge from an inpatient psychiatric unit.
- The member has been admitted to an inpatient psychiatric unit and has been identified as high risk by Optum Behavioral Health.
- Coverage of TCM is not available beyond the 30-day period unless the member meets the criteria for TCM.

Admission Criteria – ICM Adults

- The member is 18 years of age or older; and
- The member meets at least one of the following requirements:
- The member has resided in a state mental hospital for at least 6 months in the past 36 months.

- The member has had 3 or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months.
- The member resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.
    - If the member has relocated from a Department of Children and Families (DCF) district or region where he/she was receiving ICM, the member does not need to meet the above criteria.

Service Delivery

- The case manager assesses each recipient of TCM/ICM as soon as possible commensurate with the member's needs but no later than 30 calendar days from first receiving TCM/ICM.
- The assessment includes information provided by:
- The member;
- The referring person or agency;
- The member's family and friends (with consent);
- The school district (for members under age 18 or who are still attending school;
- Previous treating providers.
- The case manager makes at least 1 home visit prior to completion of the assessment. If a home visit is not possible, the case manager conducts a face-to-face interview with the member in another setting.
- The case manager creates an Individual Service Plan within 30 days of initiating ICM/TCM.
- Services and service frequency reflect the member's, needs, goals, and abilities and must not simply reflect the Medicaid maximum allowable for this service (48, 15-minute units per day of ICM, 344 15-minute units per month of TCM).
- For members receiving ICM, the case management team is available 24 hours per day, 7 days per week.
- The case manager convenes case staffing at major decision points during the member's involvement with the behavioral health system such as movements to a lesser or more restrictive environment in the community, or transfers to or from state hospitals.
- Case staffing conferences are attended, as appropriate, by the member, family members, service providers and significant others.
- The case manager ensures that service plan goals and objectives are consistently pursued and assesses progress toward the achievement of goals and objectives through monitoring activities such as telephone calls, home visits, case and treatment reviews, interviews and site visits.
- When a member misses an appointment related to the service plan or is absent from a treatment program without notification, the case manager attempts to contact the member by telephone or face-to-face meetings within 24 hours. If initial attempts to contact the client are unsuccessful, the case manager makes additional efforts by telephone, face-to-face meetings, or correspondence. Upon contacting the member, the case manager explores the reason for the absence or the missed appointment and works with the member to resolve issues inhibiting the implementation of the service plan.
- The service plan is reviewed and revised as significant changes occur in the member's condition, situation, or circumstances, but no less frequently than every 6 months.
- The service plan review is a process conducted to ensure that services, goals, and objectives continue to be appropriate to the member's needs and to assess the member's progress and continued need for TCM/ICM. The member's eligibility for TCM/ICM is re-evaluated during the service plan review.
- Evaluation and Service Planning: Additional Clinical Best Practices for Members in a Statewide Inpatient Psychiatric Program (SIPP)
- TCM is available for children in a SIPP for the last 180 days prior to discharge.
- For continuity, TCM is provided by the agency located in the same district as the member's aftercare placement.
- If a case manager is assigned prior to or at the time of placement, the case manager does the following:
    - Provides relevant information to SIPP staff regarding the member's strengths as well as problems and symptoms that have resulted in the need for placement.
    - Informs the SIPP of previous mental health interventions and services, the member's response to these services, and of significant individuals involved with the member.
- TCM services provided to the member include the following:
- Meeting the member, parent or guardian, and contacting other people (guardian ad litem, child welfare, community-based care, and other agencies) to explain the role of the case manager for a member in a SIPP placement.
- Attending at least 1 team meeting monthly and determine if treatment plan goals address the problems and symptoms that resulted in the need for the member's restricted placement and the child's strengths and assets. For children who are placed out of district, attendance may occur by phone.

- Having face-to-face contact with the member and the member's therapist monthly and contact with the family or guardian to support the family's involvement in treatment and to further the treatment and discharge planning goals. If the case manager is unable to visit the member, the case manager must call the member at least once every 14 days.
- Assisting the parent or guardian in coordinating aftercare services in the home, school, and community environments to assess and assist the member's transition and adjustment to discharge placement.
- Recommending and implementing any changes or revisions to the aftercare services array, as needed.
- After discharge, collecting outcome data to include a two-month follow-up and reporting the information to the SIPP.
- TCM services for members in a SIPP are limited to 8 hours monthly. This limit may be increased to 12 hours monthly during the last month of the member's SIPP placement to facilitate implementation of the aftercare plan.
- Evaluation and Service Planning: Additional Clinical Best Practices for Members in a State Mental Health Facility
- ICM is available for members in a state mental health facility for the last 60 days prior to discharge.
- The case manager carries out linkage and brokerage activities in the community prior to the member's discharge in order to implement the service plan.
- The case manager has face-to-face contact with the member within 2 business days of discharge.

Therapeutic Behavioral Health Onsite Services

Florida Medicaid covers TBOS (including documentation, education, and referrals) in accordance with the applicable Florida Medicaid fee schedule or as specified in this policy. Therapeutic behavioral on-site services must focus on maintaining a recipient in his or her home to avoid placement in more restrictive settings. Recipients must undergo an assessment indicating a need for TBOS and have a treatment plan based on the assessment and input from the recipient and his or her family that identifies needs, strengths, and desired outcomes. The treatment plan must also identify and provide justification for services delivered in a group setting. Individualized treatment teams must coordinate the delivery of TBOS. Therapeutic behavioral on-site services, including those delivered to the family, must focus on the recipient. Florida Medicaid does not cover services that are independent of meeting the recipient's needs. Providers must deliver TBOS in community settings, including the home and school.

Admission Criteria

- The member meets one of the following criteria:
- The member is under the age of 2 years and meets one of the following criteria:
    - The member exhibits symptoms of an emotional or behavioral nature that are atypical for the member's age and development that interferes with social interaction and relationship development; or
    - The member if failing to thrive due to emotional or psychosocial causes, not solely medical issues.
- The member is ages 2 years through 5 years and meets both of the following criteria:
    - The member exhibits symptoms of an emotional or behavioral nature that are atypical for the member's age and development; and
    - The member scores in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.
- The member is ages 6 years through 17 years and meets one of the following criteria:
    - The member has an emotional disturbance; or
    - The member has a serious emotional disturbance.
- The member is ages 18 through 20 years, but otherwise meets the criteria for an emotional disturbance or serious emotional disturbance.

Service Delivery

- Prior to the development of a treatment plan the provider completes and provides to the member/member's parent or guardian an assessment of the member's mental status, substance use concerns, functional capacity, strengths, and service needs or must have an assessment on file that has been conducted in the last 6 months.

- For members under the age of 6 years, a comprehensive behavioral health assessment completed within the last year satisfies the current assessment requirement.
- The treatment plan contains:
- A list of services:
    - Therapy services include individual and family therapy, as well as collaborative development of the formal discharge plan;
    - Behavior management services include monitoring on interactions intended to improve behavior and the member and family's skill deficits and assets, development of a behavior plan and integration of the plan into the member's overall treatment plan, training the member's family and others in implementing the behavior plan, monitoring interactions between the member and the member's family and others to measure progress, and coordinating services;
    - Therapeutic support services include 1:1 supervision and intervention with the member during therapeutic activities, skills training, and assistance to the member and the member's family and others implementing the member's behavior plan;
        - The amount, frequency, and duration of each service for the 6-month duration of the treatment plan. It is not permissible to use terms "as needed", "p.r.n.", or to state that the member will receive a service "x two times per week";
        - Dated signature of the member/member's parent or guardian;
        - If the member's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided in the treatment plan;
        - Signature of the treatment team members who participated in development of the plan;
        - A signed and dated statement by the treating provider that services are medically necessary and appropriate to the member's diagnosis and needs; and
        - Discharge criteria.
- Providers delivering services to members under the age of 6 years must have training and experience in infant, toddler, and early child development as well as methods for observing and assessing young children.
- The provider in conjunction with the individualized treatment team and, whenever possible, the member/member's parent or guardian conducts a formal review of the treatment plan at least every 6 months. The treatment plan is reviewed more often than once every 6 months when significant changes occur.
- The treatment plan review is a process conducted by the treatment team to ensure that treatment goals, objectives, and services continue to be appropriate to the member's needs and to assess the member's progress and continued need for services.
- The treatment plan review contains all of the following components:
- Current diagnoses and justification for any changes;
- The member's progress toward meeting individualized goals and objectives;
- The member's progress toward meeting individualized discharge criteria;
- Updates to the aftercare plan;
- Findings;
- Recommendations;
- Dated signature of the member/member's parent or guardian;
- Signatures of the treatment team members who participated in the review of the plan;
- A signed and dated statement by the treating provider that services are medically necessary and appropriate to the member's diagnosis and needs.
- The updated treatment plan and progress notes reflect how services are coordinated with services delivered to the member by other providers
- If the treatment plan review indicates that goals and objectives have not been met, documentation must reflect the treatment team's reassessment of services and justification if no changes are made.
- The provider and the member/member's parent or guardian develop an initial discharge plan within 45 calendar days of admission to Therapeutic Behavioral On-Site Services. The discharge plan includes measurable criteria that will be used to identify the member's readiness to transition to a new level of care or out of care. The discharge plan also includes community resources, activities, services, and supports that will be utilized to help the member sustain gains achieved during Therapeutic Behavioral On-Site Services.

- Therapeutic behavioral on-site services consist of behavior management, support, and therapy services, as follows: − Up to nine hours of behavior management services per month, per recipient that consist of all of the following: o Continuous monitoring and assessment of interactions that motivate, maintain, or improve recipient behavior and the skill deficits and assets of the recipient and recipient's family o Development of an individual behavior plan with measurable goals that must be integrated into the treatment plan o Training the recipient's family, caregivers, and other individuals involved in implementing the treatment plan o Measuring the recipient's progress toward meeting the goals listed on the treatment plan o Coordinating services listed on the treatment plan − Up to 32 hours of therapeutic support services per month, per recipient that consist of all of the following: o One-to-one supervision and intervention with the recipient during therapeutic activities in accordance with the treatment plan o Providing skills training in accordance with the recipient's treatment plan to improve the recipient's functioning and restore basic living and social skills o Assistance to the recipient and his or her family with implementing the treatment plan through family counseling and treatment plan development − Up to nine hours of therapy services per month, per recipient that consist of all of the following: o Clinical, strength-based assessment to evaluate, define, and determine treatment needs o Individual and family therapy o Assessment and engagement of the recipient and his or her family's natural support system to assist with implementing the treatment plan o Collaborative development of the formal aftercare plan Providers must complete a formal aftercare plan within 45 days of admission to TBOS. The aftercare plan must include community resources, activities, services, and supports that will sustain the gains achieved by the recipient during treatment

Therapeutic Group Care Services

Florida Medicaid therapeutic group care (TGC) services provide community-based residential, behavioral health treatment to increase coping skills and functional abilities and reduce psychiatric symptoms or disruptive behaviors, enabling recipients to return to a less restrictive environment.

Service Delivery

- The treatment plan must be completed within 14 days of admission and a psychiatrist must interview the member and conduct a formal treatment plan review monthly or when significant changes occur.
- If the treatment plan contains an individualized behavior management component, the behavior analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives.
- If a parent or guardian, team member or school personnel are not at a treatment plan meeting, the record must reflect that a staff person contacted them for their input.
- The psychiatrist must interview each member monthly to assess progress toward meeting treatment goals, or more often if medically necessary.
- Providers must provide the care and services required for a recipient to attain or restore the highest practicable physical, mental, and psychosocial well-being in accordance with Rule Chapter 65E-9, F.A.C., as follows:
- Aftercare and follow-up services
- Behavior analysis services
- Coordination with the recipient's primary care physician(s)
- Education services in accordance with Rule 6A-6.0361, F.A.C.
- Family therapy services
- Individualized treatment plan developed within 14 days after admission
- Individual and group therapy services
- Psychiatric, psychological, substance abuse, and biopsychosocial assessments and monitoring
- Recreational services
- Rehabilitative services
- Therapeutic home assignment
- Vocational services (for recipients ages 16 years and older)
- Therapeutic home assignments require daily clinical intervention with the family by the recipient's physician, primary therapist, certified behavior analyst, or other licensed practitioner.

In Lieu of Services Evidenced-Based Practices (EBPs)

EVIDENCE-BASED PRACTICES (EBP) are Home and Community Based Treatment modalities designed for individuals with complex health needs that include an array of services to meet the continuum of care.

EBP services include but are not limited to Multisystemic Therapy (MST), Functional Family Therapy (FFT), Home Builders, Community Based Wraparound Services, Family Training for Child Development and First Episode Psychosis. While models of EBPs vary, the overarching goals of these services are as follows:

- Improve Care and Access, reduce the need for acute care services and improve quality of care.

Home Builders®

Homebuilders® is an intensive, in-home Evidence-Based Program (EBP) utilizing research-based strategies (e.g., Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders) or being reunified from placement. Homebuilders® is provided through the Institute for Family Development (IFD).

- Homebuilders® participants demonstrate the following characteristics:
    - Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
    - Family members with substance abuse problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);
    - Babies that were born substance-exposed or considered failure to thrive;
    - Teenagers/adolescents that run away from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol use, and/or experience parent-teen conflict(s);
    - Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma.

- The goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems, and improve parenting skills, family interactions, and family safety to prevent the imminent need for placement or successfully reunify children.
- The Homebuilders® model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior, and well- being, family safety and the family environment.
- The children are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities.
- Homebuilders® is specifically aimed toward children and families identified with:
    - Caregiver and/or child emotional/behavioral management problems;
    - Trauma exposure;
    - Incorrigibility;
    - Academic problems;
    - Delinquency;
    - Truancy;
    - Running away;
    - Family conflict and violence;
    - Poor/ineffective parenting skills;
    - Single parent families;
    - Sibling antisocial behavior;
    - Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices;
    - Substance use;
    - Mental health concerns (depression/mood disorders, anxiety, etc.); and/or
    - Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources.
- The primary intervention components of the Homebuilders model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals. Therapists provide a wide range of counseling services using research-based motivation enhancement and cognitive behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. In addition, therapists help families enhance their social support network and access basic needs such as food, shelter, and clothing.

NOTE: The term "counseling" throughout the Homebuilders® section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by licensed medical health professionals (LMHPs) under their respective scope of practice license.

- Homebuilders® consists of:
  - Intensity: An average of eight to ten hours per week of face-to-face contact, with telephone contact between sessions. Therapists schedule sessions during the day, evening and on weekends with 3-5 or more sessions per week based on safety and intervention needs;
  - Duration: Four to six weeks. Extensions beyond four weeks must be approved by the Homebuilders consultant. Two aftercare 'booster sessions' totaling five hours are available in the six months following referral. Additional booster sessions can be approved by the Homebuilders consultant; and
  - Crisis Intervention: Homebuilders therapists are available 24/7 for telephone and face to face crisis intervention.

Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The family has a child/children ages birth to 18 years old at imminent risk of out of home placement due to at least one of the following:
  - Caregiver and/or child emotional/behavioral management problems
  - Trauma exposure
  - Incorrigibility
  - Academic problems
  - Delinquency
  - Truancy
  - Running away
  - Family conflict and violence
  - Poor/ineffective parenting skills
  - Single parent families
  - Sibling antisocial behavior
  - Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices
  - Substance use
  - Mental health concerns (depression/mood disorders, anxiety, etc.)
  - Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources

  AND
- Other than psychological evaluation, assessment and medication management, all behavioral health services are provided by Homebuilders.
  AND
- The member is not receiving residential services.

Continuing Stay Criteria

- The member is receiving an average of 8 to 10 hours per week of face-to-face contact, with telephone contact between sessions.
- Therapists schedule sessions during the day, evening and on weekends with 3-5 or more sessions per week based on safety and intervention needs.
- Homebuilders' therapists are available 24/7 for telephone and face to face crisis intervention.

Discharge Criteria

- The duration of services is 4 to 6 weeks. Extensions beyond 4 weeks must be approved by the Homebuilders consultant. Two aftercare 'booster sessions' totaling 5 hours are available in the 6 months following referral. Additional booster sessions may be approved.

Multisystemic Therapy

Multisystemic Therapy (MST) is an EBP that provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and BH issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

Admission Criteria

- The member is 12-17 years old.
- The member exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
- The member is at risk for out-of-home placement or is transitioning back from an out-of-home setting.
- The member has externalizing behaviors and symptomatology resulting in a DSM-5 diagnosis of Conduct Disorder or other diagnoses consistent with such symptomatology.
- There is ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems.
- Less intensive treatment has been ineffective or is inappropriate.

Continuing Stay Criteria

- Treatment does not require more intensive level of care.
  AND
- The treatment plan has been developed, implemented and updated based on the member's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
  AND
- Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.
  AND
- The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Discharge Criteria

- The member's treatment plan goals or objectives have been substantially met.
- The member meets criteria for a higher or lower level of treatment, care or services.
- The member, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment.
- Consent for treatment has been withdrawn, or the member and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

Service Delivery

- MST services may not be clinically appropriate for individuals who meet the following conditions:
  - Members who meet the criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior.
  - Members living independently or members whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers.
  - The referral problem is limited to serious sexual misbehavior in the absence of other delinquent or antisocial behavior.
  - Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;
  - Low-level need cases; or
  - Members who have previously received MST services or other intensive family- and community-based treatment.

- On average, a youth receives MST for 3 to 5 months, but typically, no longer than five months.
- The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need.
- Families typically see therapists less frequently as they get closer to discharge. On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems).
- The MST model is intended to be a highly individualized treatment that is intensive and is delivered as frequently as is required to produce the outcomes desired for each specific youth).
- Services occur in the family's home or community at times that are convenient for the family.
- Staff members are expected to work on weekends and evenings, for the convenience of their members.
- Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support. Each therapist carries a small caseload (four to six families) at any one time.
- MST includes the following:
    - Assessment;
    - Ongoing treatment planning;
    - Family therapy;
    - Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals);
    - Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors;
    - Individual therapy may occur but is not the primary mode of treatment; and
    - Referral for psychological assessment, psychiatric evaluation and medication management, if needed.
- Unless it directly impacts the youth's treatment, MST therapists do not provide individual therapy to caregivers or other family members, or marital therapy.

Exclusions

- MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management.
- MST shall not be billed in conjunction with residential services.

Functional Family Therapy

Functional Family Therapy (FFT) is a systems-based EBP model of prevention and intervention that incorporates various levels of the member's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as interpersonal perspectives which focus on the family and other systems within the environment that impact the member and their family system.

FFT is a strengths-based model that emphasizes the use of existing resources of the member, their family and those of the involved multi-system. The goal is to foster resilience and decrease incidents of disruptive behavior. The service aims to reduce intense/negative behavioral patterns, improve family communication, parenting practices and problem-solving skills, and increase the family's ability to access community resources.

FFT services target members between the ages of 10-18 primarily demonstrating significant externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. The member may also meet criteria for a disruptive behavior disorder (ADHD, ODD and/or conduct disorder). Members with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing condition manifests in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if FFT is deemed clinically more appropriate than focused drug and alcohol treatment and acting out behaviors are present to the degree that function is impaired, and the criteria listed below is met.

Admission Criteria

The member is not in imminent or current risk of harm to self, others, and/or property.

- The member is 10-18 years old
- At least one adult caregiver is available to provide support and is willing to be involved in treatment.
- The member's DSM-5 diagnosis is the primary focus of treatment and symptoms, and impairment are the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary.

- Functional impairment is not solely a result of pervasive developmental disorder or intellectual disability.
- The member displays externalizing behavior which adversely affects family functioning. The member's behaviors may also affect functioning in other areas.
- Documented medical necessity for an intensive in-home service.

Continuing Stay Criteria

- The member receives an average of 12 to 30 one-to-two-hour sessions in the home or community depending on the member's needs over the course of 3-5 months.
- There are three domains of assessment used to monitor progress towards goals including the following:
    - Member assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):
        - Helps understand individual, family and behavior in a context functioning;
        - Adds to clinical judgment, helps target behavior change targets, tool in treatment.
    - Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):
        - Helps understand the outcome of your work – accountability; and
        - Identifies changes in member functioning (pre-post).
    - Case monitoring and tracking (member service system reports):
        - Every member contact/planned contact, outcome of that contact (helps monitor practice).

Discharge Criteria

- The member and family demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

Service Delivery

- On average, a youth receives FFT for approximately 3 to 5 months. Over the course of this period, the therapist works with the family in twelve to fifteen one- to two-hour sessions for less severe cases and up to 30 -one- to two-hour sessions for youth with more complex needs.
- The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed.
- Services occur in the office, family's home and/or community at times that are convenient for the family. In addition to being available to families as needed (intensity is based on family risk and protective factors), FFT therapists provide regular telephonic follow-up and support to families between sessions.
- Outreach and linkages made with community supports are an essential part of the model, particularly during pre-treatment, engagement, and generalization phases; this includes non-face-to-face and telephonic contact with these sources, with or without the member present.
- The FFT therapist must work with any treatment planning team members.

Community-Based Wraparound

Community-Based Wraparound is an EBP that forms a wraparound team consisting of the member's family, extended family, and other community members involved with the member's daily life for the purpose of producing a community-based, individualized Plan of Care. This includes working with the family to identify who should be involved in the wraparound team and assembly of the wraparound team for the Plan of Care development meeting.

Community Based Wraparound is an individualized care planning and management service for children with complex needs. It includes structured, creative team meetings and care plans designed to meet the unique needs of children, caregivers and families. Wraparound team meetings include a child's treatment team, social supports, non-traditional supports, and family members. Services are provided at flexible times and locations to accommodate the child's and family's needs. treatment/Service Plans are frequently reviewed and updated. The emphasis is on integrating and maintaining the child in the community and building the child's and family's support network.

Admission Criteria

- The member is under the age of 21 with a diagnosis of Severe Emotional Disturbance who could benefit from community-based wraparound as a diversion to higher levels of care.
- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the waiver member's medical record.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.
- Services are provided by a Certified Targeted Case Management (TCM) agency and the individual rendering services must be certified as a TCM through the Florida Certification Board
- Providers must be supervised and coaching is provided by a certified TCM supervisor trained and certified as a Wraparound Coach.

Continued Service Criteria

- The wraparound team along with the member have created an individualized Care Plan to address the unique strengths and needs of the family.
- The family is engaged and actively participating according to the Care Plan.
- There is progress toward Care Plan goals that are focused, measurable and outcome driven.

Discharge Criteria

- The duration of services depends on the specific needs of the family and the goals outlined in the Individualized Care Plan.
- Typical duration of services is 3-24 months

Exclusion Criteria

- The member has needs that can be effectively addressed with lower intensity services.
- The family refused to participate

Service Delivery

- The wraparound coach guides the Plan of Care development process.
- The wraparound coach also is responsible for reassembling the team when subsequent Plan of Care review and revision are needed, at minimum on a yearly basis to review the Plan of Care and more frequently when changes in the member's circumstances warrant changes in the Plan of Care.
- The wraparound coach will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the waiver member and family/caregivers.
- Coaches are to be certified after completion of specialized training in the wraparound philosophy, waiver/grant rules and processes, waiver/grant eligibility and associated paperwork, structure of the waiver member and family team, and meeting facilitation.

Family Training for Child Development

Family Training for Child Development are services to help caregiver(s) understand and manage a member's behavioral needs related to a Serious Emotional Disturbance (SED) diagnosis and to promote the member's development.

Admission Criteria

- The member is under the age of 21 and has a Serious Emotional Disturbance diagnosis
- The caregivers are in need of services to support and promote the member's functioning.
- There is not a need for a more intensive level of service.
- The member is not required to be present, but may be if appropriate.

Service Delivery

Services include:

- Support groups or individual sessions for family members;
- Psychosocial activities; and other education and support activities related to SED in children.
- Family training and support does not include services that require a professional clinical license. However, services must be consistent with the provider's qualifications.
- Services are provider no more than 9 hours per month

First Episode Psychosis

First Episode Psychosis (FEP) is a term used to describe a recent onset of overt psychotic symptoms, particularly delusions and/or hallucinations that are at times indistinguishable from reality, or disorganized speech that is tangential or incoherent. FEP occurs in late adolescents or young adults whose symptoms cross the threshold for a psychotic episode within the past 2-5 years. These symptoms occur frequently (e.g., averaging at least 1 hour per day, 3-6 times per week for 1 month) and may be seriously disorganizing or dangerous to oneself or others. Though the specific clinical presentation of FEP is diverse and individualized across individuals, many symptoms will fall into one of several characteristic symptom clusters as defined by the DSM-5.

Initial Coverage Criteria

- An assessment of the member's symptoms with the use of validated rating scales (e.g., SIPS, CAARMS) has been completed and indicates the following:
- The member has been experiencing psychotic symptoms or may meet criteria for a psychotic spectrum disorder defined by the DSM-5. Symptoms include:
    - Delusions
    - Hallucinations
    - Disorganized speech
    - Grossly disorganized behavior (e.g., catatonia)
    - Negative symptoms (e.g., dampened emotions, diminished speech or responsiveness);
- The member is in late adolescence or early adulthood (e.g., "emerging adulthood" – ages 15-35);
- The onset of psychotic symptoms has occurred within the last 2-5 years;
- Symptoms displayed are consistent with one of several symptom clusters (positive, negative, and disorganization of thinking, speech, and/or behavior);
- Psychotic symptoms persisting for longer than 1 week and with a frequency of at least 3-6 times a week for longer than 1 hour each time; or daily for less than one hour each time; and
- The assessment has ruled out psychosis due to the physiological effects of drugs of abuse, medications and medical conditions.

Evaluation and Treatment Planning

- The comprehensive assessment includes the use of one of the following evidence-based screening tools to identify the symptoms consistent with FEP:
- Structured Interview for Psychosis-risk Syndromes (SIPS)
- Comprehensive Assessment of At-Risk Mental States (CAARMS)
- Positive Symptoms and Diagnostic Criteria (PSYCHS)
- A differential diagnosis is completed according to the DSM-5 and one of the following diagnostic tools:
- Structured Clinical Interview for DSM-5 (SCID-5)
- Schedule for Affective Disorders and Schizophrenia (SADS; K-SADS for youth)
- The individualized assessment includes:
- Evaluation of safety and urgent needs
- Identification of comorbidities and ruling out of other conditions
- Severity of symptoms present
- Review of treatment history and treatment goals

- Identification of family and supports
- Determination of the level of intervention needed, or whether intervention is warranted
- Identification and selection of the appropriate evidence-based interventions available through the development of an individualized treatment plan.

- Treatment planning should involve shared decision making with the following considerations:
- Engaging family and peer supports
- Strategizing for care management/coordinated care and addressing comorbidities
- Offering evidence-based interventions including psychotherapy and pharmacotherapy
- Monitoring treatment outcomes and side effects

- Early intervention can be critical for improving chances of recovery influencing symptom reduction, suicide risk, criminal justice involvement, quality of life, social functioning and treatment response for individuals identified with FEP.

Treatment Interventions: First Episode Psychosis (FEP) Specialty Program/ Coordination Specialty Care Interventions (CSC)

- Early intervention services for individuals experiencing FEP may include evidence-based outpatient Coordinated Specialty Care services. Coordinated Specialty Care (CSC) is a team-based, multi-element approach to treating FEP and may include some or all of the following interventions:

- **Recovery-oriented psychotherapy**
    - Individual psychotherapy for first episode psychosis is based on cognitive-behavioral treatment principles and emphasizes resilience training, illness and wellness management, and general coping skills pertinent to young adults experiencing a their initial psychotic episodes. Psychological interventions are essential for symptomatic and functional recovery, and may aid in the prevention of comorbidities, such as nicotine addiction and substance abuse.
    - Treatment consists of core and supplemental modules and is tailored to each client's needs. Individuals and psychotherapists work one-on-one or in groups, meeting weekly or bi-weekly, with the duration and frequency of sessions personalized for each individual.
    - Psychotherapy—individual or group—aims to restore the person's feelings of personal wellness, reinforce coping and resilience, and lessen the likelihood of subsequent psychotic episodes and prevent or treat co-morbidities.

- **Family psychoeducation and support**
    - First episode psychosis can have a devastating impact on the individual's relatives and other support persons, who struggle to adjust to changed circumstances and new demands. Family psychoeducation and support teaches family members or other individuals providing support about psychosis and its treatment and strengthens their capacity to aid in the individual's recovery.
    - Education about psychosis and its treatment is recommended for all families during the initial phase of FEP care. Increasing relatives' understanding of psychotic symptoms, treatment options, and the likelihood of recovery can lessen family members' distress and feelings of helplessness. In addition, an alliance between the CSC team and family members often helps to maintain contact with the client in the event that psychotic symptoms reoccur.

- **Supported employment and education**
    - For young adults, first episode psychosis can impede attempts to obtain or maintain employment. Supported employment services are offered to all clients who want to work in order to help them choose and get a job that aligns with their career goals. Supported employment emphasizes rapid job placement in the individual's preferred work setting. Ongoing supports are also available to help the individual maintain employment.
    - The experience of first episode psychosis can disrupt school attendance and academic performance. Supported education services facilitate an individual's return to school, as well as attainment of expected educational milestones. Supported education emphasizes rapid placement in the individual's desired school setting and provides active coaching and support to ensure the individual's educational success.
    - Young individuals with psychotic disorders are often in school or are establishing their initial work career. Resumption of normal educational or vocational activity is a common goal for individuals and family members.

- **Pharmacotherapy and primary care coordination**

- Guideline-based use of medication optimizes the speed and degree of symptomatic recovery by individuals with first episode psychosis and minimizes the likelihood of side effects. Pharmacotherapy is best initiated following a thorough medical evaluation to assess for all possible causes of psychosis. Pharmacotherapy typically begins with a low dose of a single antipsychotic medication and involves monitoring for symptom response, side effects, and attitudes towards medication at every visit.
- Special emphasis on monitoring and managing cardiometabolic risk factors such as smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes. Prescribers maintain close contact with primary care providers to assure optimal medical treatment for risk factors related to cardiovascular disease and diabetes.
- The medical care of young people during the early stages of mental illness is considerably different in style and content compared to approaches used in older individuals with established illness.

- **Case management**
  - Case management assists individuals with solving practical problems and coordinates services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the young person and their family, with sessions occurring in clinic, community, and home settings, as required.
  - Individuals who experience FEP frequently need assistance with practical problems such as obtaining medical care, managing money, securing transportation, navigating the criminal justice system, and procuring stable housing.
  - Successful treatment of individuals with FEP often requires a high degree of coordinated care which is effectively delivered using a case management model.
- **FEP specialty programs/ CSC provide six critical functions for young people experiencing a first episode of psychosis:**
- Access to clinical providers with specialized training in FEP care;
- Easy entrée to the FEP specialty program through active outreach and engagement;
- Provision of services in home, community, and clinic settings, as needed;
- Acute care during or following a psychiatric crisis;
- Transition to step-down services with the FEP team or discharge to regular care after an average of 2-3 years, depending on the individual's level of symptomatic and functional recovery; and
- Assurance of program quality through continuous monitoring of treatment fidelity.

Other Evidence-Based Interventions

- Family Interventions such as Problem Solving Based Self-Learning and Mutual Family Support
- Antipsychotic medication other than clozapine for the treatment of an acute episode in individuals with first-episode psychosis who have previously responded to antipsychotic medications. The choice of antipsychotic medication should be based on an individualized evaluation that considers patient characteristics and side effect profiles of the different antipsychotic medications.
- Medication choice should be a shared decision based on benefits versus adverse effects considering starting doses and rates of titration at the lower end of the dose range established for each agent.
- Assertive Community Treatment
- Psychosocial Rehabilitation and Recovery Centers
- CBT, CBT for psychosis (CBTp), or both (If the individual has had a prior course of CBT or CBTp, consider booster sessions or another psychotherapy, such as acceptance- or mindfulness-based therapies, positive psychotherapies, or meta-cognitive therapy.)
- Skills training for impairments in social skills
- Cognitive training, cognitive remediation, or both for cognitive deficits
- Illness self-management approaches (e.g., illness management and recovery)
- Evidence-based psychotherapies for comorbid disorders
- Caregiver-directed psychosocial interventions for family, others with whom the individual with schizophrenia maintains close contact and chooses as family, or both
- Peer support and peer support groups
- Interventions to assist individuals with coping with stigma, addressing self-stigma, and issues of disclosure

Continuation and Transition

- Determining whether continuation of treatment or if the member is ready for transition to a less intensive level of care should be a collaborative process involving the individual, their relatives and important others.
- Most FEP programs are designed for up to a 24-month duration depending on the individual's progress, clinical needs and treatment plan.
- There should be ongoing assessment of the member's progress in achieving treatment goals in key domains (e.g., school and work functioning, quality of peer and family relationships, relief from symptoms, abstinence from substances, effective management of health issues) and identification of areas that require additional work.
- An important consideration in planning the transition is the member's personal vision of stability, success in community functioning, and personal autonomy.
- Transition planning parameters can be used to guide the transition process.
- Consider the following monitoring/transition parameters:
- Reduction core symptoms and/or symptom stabilization.
- Treatment adherence and self-management skills.
- Employment/educational stability.
- Family and social support.
- Relapse prevention skills.
- Lab parameters - measure at baseline, three months (for clozapine and olanzapine) and at least annually thereafter if treated with antipsychotic medications.
- Vitals (weight, temperature, blood pressure, HR changes, orthostatic hypotension, autonomic instability, unexplained fever).
- Functioning (social functioning, intimacy, sexuality, parenting, workplace, education, family or other primary support group, interpersonal baseline changes).
- Durable planning needs (financial; guardianship; medical, legal, or both; will).
- Individual goals and preferences.
- Life circumstances changes.
- A clear transition plan has been established.

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Revision History

Date	Summary of Changes
05/09/2018	Version 1
01/31/2019	Version 2
01/31/2020	Version 3
01/31/2021	Version 4
04/15/2022	Version 5
04/15/2023	Version 6
02/13/2024	Version 7
12/17/2024	Version 8
01/01/2025	Version 9
05/20/2025	Version 9 Update – Fee Schedule