



## MEDICAL POLICY STATEMENT GEORGIA MEDICAID

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<b>Policy Name</b>		<b>Policy Number</b>
Intensive Customized Care Coordination		MM-0213
<b>Policy Type</b>		
<b>MEDICAL</b>	Administrative	Pharmacy
		Reimbursement

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### Contents of Policy

<u>MEDICAL POLICY STATEMENT</u> .....	1
<u>TABLE OF CONTENTS</u> .....	1
<u>A. SUBJECT</u> .....	2
<u>B. BACKGROUND</u> .....	2
<u>C. DEFINITIONS</u> .....	3
<u>D. POLICY</u> .....	3
<u>E. CONDITIONS OF COVERAGE</u> .....	8
<u>F. RELATED POLICIES/RULES</u> .....	8
<u>G. REVIEW/REVISION HISTORY</u> .....	8
<u>H. REFERENCES</u> .....	8



## A. SUBJECT

### **Intensive Customized Care Coordination**

## B. BACKGROUND

Intensive Customized Care Coordination is a provider-based High Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought. Intensive Customized Care Coordination encourages the use of community resources through referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Intensive Customized Care Coordination is a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, securing, and reviewing the delivery and outcome of appropriate services for individuals through a wraparound approach. Care Coordinators (CC), who deliver this intervention, work in partnership with the individual and their family/caregivers/legal guardian are responsible for assembling the Child and Family Team (CFT), including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address individual health and safety issues.

Intensive Customized Care Coordination is differentiated from traditional case management by:

- Coaching and skill building of the individual and parent/caregiver to empower their self-activation and self-management of their personal resiliency, recovery and wellness towards stability and independence.
  - The intensity of the coordination: an average of three hours of coordination weekly.
  - The frequency of the coordination: an average of one face-to-face meeting weekly.
  - The caseload: an average of ten youth per care coordinator.
  - Service duration may be up to 18 months
  - Involvement in a partnership with a High Fidelity Wraparound-trained certified parent peer specialist (CPS-P) as a part of the Wrap Team (this CPS-P, while a required partner in the ICCC process, is billed separately as Parent Peer Support in accordance with this manual [CMO only]).
  - Development of a Child and Family Team, minimally comprised of the individual, parent/caregiver, and Wrap Team (CC, CPS-P, and one natural support)
  - A Child and Family Team Meeting (CFTM), held minimally every 30 days, where all decisions regarding the Individual Recovery Plan are made
- Intensive Customized Care Coordination includes the following components as frequently as necessary:
- Comprehensive youth-guided and family-directed assessment and periodic reassessment of the individual to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, developmental or other services and include activities such as: taking individual history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual.
  - Development and periodic revision of an individualized recovery plan (IRP), based on the assessment, that specifies the goals of providing care management and the actions to address the medical, social, educational, developmental and other services needed by the individual, including activities that ensure active participation by the individual and others. The IRP will



include transition goals and plans. If an individual declines services identified in the IRP, it must be documented.

- Referral and related activities to help the individual obtain needed services/supports, including activities that help link the eligible individual with medical, social, educational, developmental providers, and other programs or services that are capable of providing services to address identified needs and achieve goals in the IRP.
- Monitoring and follow-up activities that are necessary to ensure that the IRP is effectively implemented and adequately addresses the needs of the individual. Monitoring includes direct observation and follow-up to ensure that IRPs have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services and the ongoing evaluation of the satisfaction of individuals and their families/caregivers/legal guardians with the IRP. These activities may be with the individual, family members, providers, or other entities, and may be conducted as frequently as necessary to help determine: whether services/supports are being furnished in accordance with the individual's IRP; whether the services in the IRP are adequate to meet the needs of the individual; whether there are changes in the needs or status of the individual. If changes have occurred, the individual IRP and service arrangements with providers will be updated to reflect changes.
- Intensive Customized Care Coordination may include contacts and coordination with individuals that are directly related to the identification of the individual's needs and care, for the purposes of assisting individuals' access to services, identifying needs and supports to assist the individual in obtaining services, providing Care Coordinators with useful feedback, and alerting Care Coordinators to changes in the individual's needs. Examples of these individuals include, but are not limited to, school personnel, child welfare representatives, juvenile justice staff, primary care physicians, etc.
- Intensive Customized Care Coordination also assists individuals and their families or representatives in making informed decisions about services, supports and providers.
- Partnering with and facilitating involvement of the required CPS-P.

### C. DEFINITIONS

- Certified Parent Peer Specialist (CPS-P): Provides support to parent/guardian who is raising a child living with mental health, substance abuse or a co-occurring diagnosis
- The Georgia Network for Educational and Therapeutic Support (GNETS): comprised of 24 programs which support the local school systems' continuum of services for students with disabilities, ages 3-21
- Individualized Action Plan (IAP):
- Child and Family Team Meeting (CFTM): CFTM is a meeting that is a planned event that brings together family, non-professional (such as friends, neighbors, community members) and professional resources (such as child welfare, mental health, medical, education and other agencies) that provide supports, expertise and their involvement
- Emergency Child and Family Team Meeting (ECFTM: Emergency Child and Family Team Meetings are to be held within 72 hours of a crisis)

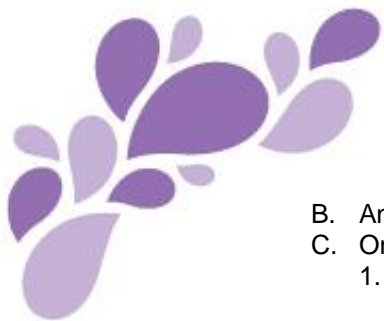
### D. POLICY

#### I. Admission Criteria

- A. An individual must meet two of the following criteria in order to be accepted into the program.
  1. Individual has shown serious risk of harm in the past one hundred and eighty (180) days, as evidenced by one of the following:
  2. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly endangering to self or others,  
OR

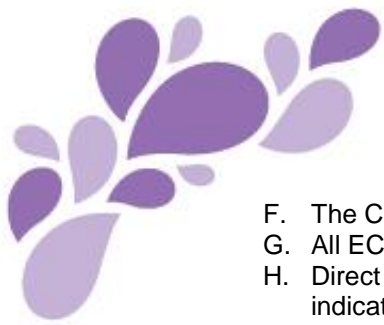


3. Recent pattern of excessive substance use (co-occurring with a mental health diagnoses as indicated in target population definition above) resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use, OR
  4. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety, OR
  5. Current suicidal or homicidal ideation with clear, expressed intentions and/or current suicidal or homicidal ideation with history of carrying out such behavior
- B. The clinical documentation supports the need for the safety and structure of treatment provided the individual's behavioral health issues are unmanageable as evidenced by:
1. Documented history of multiple admissions to crisis stabilization programs or psychiatric hospitals (in the past 12 months) and individual has not progressed sufficiently or has regressed; and one of the following:
    - 1.1 Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs; OR
    - 1.2 Past response to treatment has been minimal, even when treated at high levels of care for extended periods of time; OR
    - 1.3 Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure, OR
  2. Have experienced two or more placement changes within 24 months due to behavioral health needs in home, home school or GNET, OR
  3. Have been treated with two or more psychotropic medications at the same time over a 3-month period by the same or multiple prescribing providers, OR
  4. Youth and/or family risk of homelessness within the prior 6 months
- C. Individual and/or family has history of attempted, but unsuccessful follow through with elements of a Resiliency/Recovery Plan which has resulted in specific mental, behavioral or emotional behaviors that place the recipient at imminent risk for disruption of current living arrangement including:
1. Lack of follow through taking prescribed medications;
  2. Following a crisis plan; or
  3. Maintaining family and community-based integration
- II. Continuing Stay Criteria
- A. Individual has shown serious risk of harm due to Mental Health, Substance Use, or Co-Occurring issues in the past ninety (90) days, as evidenced by the following:
1. Some self-mutilation, risk taking or loss of impulse control resulting in danger to self or others, or
  2. Decreased daily functioning due to bizarre behavior, psychomotor agitation, or
  3. Disorientation or memory impairment due to mental health condition that endangers the welfare of self or others, or
  4. Notable impairment in social, interpersonal, occupational, educational functioning that leads to dangerous functioning, or
  5. Inability to maintain adequate nutrition or self-care with no support due to psychiatric condition, or
  6. Side effects of atypical complexity from psychotropic medication or lack of stabilization on psychotropic medication, or
  7. Persistent mood disturbance, with or without psychosis that indicates a risk of harm to self or others, or
  8. Some patterns of substance use resulting in risky or harmful behavior patterns with limited restriction capacity
- III. Discharge Criteria
- A. Youth has demonstrated a decrease in admission criteria behaviors over the past ninety (90) days. This decrease is clearly and sufficiently documented in case plans and/or medical records; and



- B. An adequate transition plan has been established; and
  - C. One or more of the following:
    - 1. Goals of Individualized Action Plan (IRP) have been substantially met and individual no longer meets continuing stay criteria; or
    - 2. Individual's family requests discharge and the individual is not imminently in danger of harm to self or others; or
    - 3. Transfer to another service is warranted by change in the individual's condition.
- IV. Service Exclusions
- A. Intensive Customized Care Coordination providers cannot bill the following services while providing Intensive Customized Care Coordination to an individual:
    - 1. Behavioral Health Assessment
    - 2. Service Plan Development
    - 3. Community Support Individual
  - B. While "care coordination" is often considered a managed care product, this service does not function in that manner. This is a direct service benefit to individual and families, provided side-by-side with them in their own homes/communities. The service includes (among other elements) provision of direct coaching, support, and training specific to developing the individual/family skills to self-manage services coordination and, as such, is not solely appropriate as a tool for utilization management
- V. Clinical Exclusions
- A. Individuals with the following conditions are excluded from admission because the severity of cognitive impairment precludes provision of services in this level of care: Severe and Profound Intellectual/developmental disabilities.
  - B. The following diagnoses are not considered to be a sole diagnosis for this service:
    - 1. Rule-Out (R/O) diagnoses
    - 2. Personality Disorders
  - C. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence that an additional psychiatric diagnosis is the foremost consideration for psychiatric intervention:
    - 1. Conduct Disorder
    - 2. Organic mental disorder
    - 3. Traumatic brain injury
  - D. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for this psychiatric intervention:
    - 1. Mild Intellectual/Developmental Disabilities
    - 2. Moderate Intellectual/Developmental Disabilities
    - 3. Autistic Disorder
- VI. Required Components
- A. Access to parent peer support shall be offered. This access is a required complement to this service. Parent Peer Support is a separate and distinct billable service.
  - B. The family must be contacted within 48 hours of the initial referral.
  - C. The family must be met face-to-face by care coordinator and/or family peer support staff within 72 hours of the initial referral to begin the engagement and assessment processes.
  - D. An initial CFTM must be held within 14 days from the initial enrollment for all individual.
  - E. CFTMs must be held at a minimum of every 30 days to minimally include the parent or legal guardian (or their representative), individual, one natural support and Wrap Team (To accommodate full participation, parent or legal guardian (or their representative), individual and natural support may participate telephonically or through other electronic means). Service providers (behavioral health and medical), child-serving agency personnel (child welfare, juvenile justice, education) and other natural and informal supports should also be a part of the Child and Family Team.

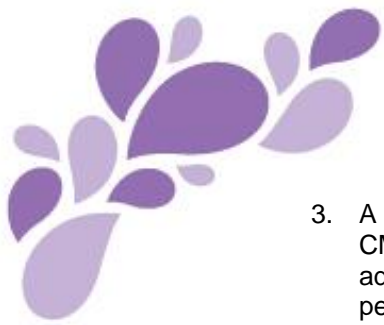




- F. The CFTM process should be family-driven and youth-guided.
- G. All ECFTMs must be held within 72 hours of a crisis.
- H. Direct supervision by the supervisor must occur at least monthly utilizing the supervision tools indicated by the National Wraparound Initiative.
- I. Group/team case consultation by the supervisor must occur at least twice monthly.
- J. Provision of direct observation of staff in the field by the supervisor at least monthly.
- K. Provision of direct observation of staff in the field by Master Trainers/Coaches.
- L. All staff must be trained in High Fidelity Wraparound through the Georgia Center of Excellence for Child and Adolescent Behavioral Health (COE) before providing this service.
- M. Ensure that families are utilizing natural supports and low-cost, no-cost options that are sustainable. Provision of crisis response, 24/7/365 to the individual they serve, to include face-to-face response when clinically indicated.
- N. The Care Coordinator will average 3 hours of care coordination per week per individual served.
- O. The Care Coordinator will average 1 face-to-face per week per individual served.
- P. To promote team cohesion, Care Coordinators must have weekly contact with the CPS-P/ on the ICCC team in support of the individual/family.
- Q. All coordination will be documented in accordance with the Department of Behavioral Health and Developmental Disabilities (DBHDD) Provider Manual for Community Behavioral Health Providers.
- R. Providers must participate in the DBHDD Care Management Entity (CME) quality improvement processes

#### VII. Staffing Requirements

- A. Intensive Customized Care Coordination providers will minimally have:
  - 1. Care Coordinators who can serve at a 10 individual to 1 care coordinator ratio:
    - 1.1 Care Coordinators must possess a minimum of B.A or B.S. degree in social work, psychology or related field with a minimum of two years clinical intervention experience in serving youth with SED or emerging adults with mental illness. All Bachelor level and unlicensed care coordinators must be supervised at minimum by a licensed mental health professional (e.g. LCSW, LPC, LMFT). Experience can be substituted for education. Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.
    - 1.2 Effective verbal and written communication skills.
  - 1.2 Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.
  - 1.3 Ability to develop and deliver case presentations.
  - 1.4 Ability to analyze complex information, and to define and solve problems.
  - 1.5 Ability to work effectively in a team environment.
  - 1.6 Ability to work in partnership with family service providers with lived experience.
- 2. Wraparound Supervisor for every six (6) care coordinators:
  - 2.1 Wraparound Supervisor must possess a minimum of M.A. or M.S. degree in social work, psychology or related field with a minimum of two years clinical intervention experience in serving youth with SED or emerging adults with mental illness. All unlicensed Wraparound Supervisors must be supervised at minimum by an independently licensed mental health practitioner (e.g. LCSW, LPC, LMFT). Education can be substituted for experience. Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.
  - 2.2 Effective verbal and written communication skills.
  - 2.3 Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.
  - 2.4 Ability to develop and deliver case presentations.
  - 2.5 Ability to analyze complex information, and to define and solve problems.
  - 2.6 Ability to work effectively in a team environment.



3. A Program Director who is responsible for the overall management of this service. The CME Director oversees the implementation of numerous activities that are critical to CME administration and management including but not limited to supervision of team personnel; model adherence, principles, values, and fidelity; participation and monitoring of continuous quality improvement.
4. A CPS-P assigned for every child/family team:
  - 4.1 This particular staff support can be declined by the legal guardian; or
  - 4.2 This particular staff support can be declined for youth who are in Department of Family and Children Services (DFCS) or Department of Juvenile Justice (DJJ) custody and for whom there is not a foster parent; or as appropriate, with a reunification plan, this CPS-P can be utilized to facilitate permanency planning and/or to facilitate increasing parental involvement in care coordination processes.

#### VIII. Clinical Operations

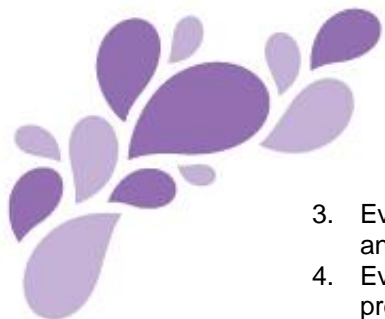
- A. Providers must adhere to the DBHDD CME Procedures Manual.
- B. Provider must accept all coordination responsibility for the individual and family.
- C. Provider must ensure that all possible resources (services, formal supports, natural supports, etc.) have been exhausted to sustain the individual in a community based setting prior to institutional care being presented as an option.
- D. Provider must ensure care coordination and tracking of services and dollars spent.
- F. Provider must ensure that all updated action plans or authorization plans are submitted to the authorizer of services per the state guidelines of 7 days after the CFTM.
- G. Provider must have an organizational plan that addresses how the provider will ensure the following:
  1. Direct supervision by the supervisor must occur at least monthly utilizing the supervision tools indicated by the National Wraparound Initiative.
  2. Group/team case consultation by the supervisor must occur at least twice monthly.
  3. Provision of oversight and guidance around the quality and fidelity of Wrap Process by the supervisor.
  4. Provision of oversight and guidance around the quality and fidelity to family-driven and youth-guided care by the supervisor.
  5. Ongoing training and support from the Center of Excellence regarding introductory and advanced Wraparound components as identified by CME Staff, COE or DBHDD in maintaining effective statewide implementation.
  6. Supervisors complete Georgia Document Review Form (see DBHDD CME Manual) with Care Coordinators monthly for each child and family team.
  7. Provision of crisis response, 24/7/365 to the youth they serve, to include face-to-face response when clinically indicated

#### IX. Service Accessibility

- A. Providers will be available for meetings at times and days conducive to the families, to include weekends and evenings for Child and Family Team meetings.
- B. Families must be given their choice of family support organizations for parent peer support, where available. If unavailable in their county, the provider of Intensive Customized Care Coordination must provide parent peer support to the family, as the Wrap Team is defined as a care coordinator and a High Fidelity Wraparound trained certified parent peer specialist (CPS-P).

#### X. Documentation Requirements

- A. The following must be documented:
  1. Youth/Young adult and family orientation to the program, to include family and individual expectations.
  2. Wrap Team progress notes are documented for all individual and family interventions and coordination interventions. These notes adhere to the content set forth in the DBHDD Provider Manual for Community Behavioral Health providers.



- 3. Evidence that the youth/young adult’s needs have been assessed, eligibility established, and needs prioritized.
- 4. Evidence of youth/young adult participation, consent and response to support are present.
- 5. Evidence that methods used to deliver services and supports to meet the basic needs of individual are in a manner consistent with normal daily living as much as possible.
- 6. Evidence of minimal participation in each CFTM as described in Required Components.
- 7. Evidence of CFTMs and ECFTMs occurring as described in Required Components
- 8. Documentation of active CPS-P participation in the team process (billed separately from the ICCC service). If this is declined in accordance with Staffing Requirement Item 4 above, the reason for declined CPS-P support is noted in the record

XI. Billing and Reporting Requirements

- A. The provider must report data to the DBHDD or COE as required by the DBHDD CME Quality Improvement Plan or any other data request.
- B. The provider must provide requested data to the DBHDD and/or DCH in their roles as state medical and behavioral health authorities.
- C. The provider must document the provision of direct observation of staff in the field by the supervisor at least monthly.
- D. The provider must document the provision of direct observation of staff in the field by Master Trainers/Coaches

XII. Additional Medicaid Requirements

- A. The Care Coordinator is responsible for seeking service authorization in accordance with the criteria herein through the benefit manager.

E. CONDITIONS OF COVERAGE

HCPCS  
CPT

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

NA

G. REVIEW/REVISION HISTORY

	DATES	ACTION
Date issued	01/22/2018	New Policy.
Date Revised		
Date Effective	07/15/2018	

H. REFERENCES

- 1. Georgia Department of Behavioral Health and Developmental Disabilities, January 1, 2018

**The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.**