COLORADO

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Appendix N

Development Disability and Traumatic Brain Injury Guidance

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Developmental Disability and Traumatic Brain Injury Guidance

DEVELOPMENTAL DISABILITY (DD)

BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD)

Providing services to individuals with both a mental illness and a developmental disability is a complicated challenge to the provider community in meeting a DD/MI individual's behavioral health needs. Co-occurring mental health disorders and developmental disabilities are relatively common. People with developmental disabilities should be afforded the same access to mental health services as the general population. The intent of this document is to ensure that the presence of a diagnosis of developmental disability does not decrease the diagnostic significance of any accompanying mental illness. A misdiagnosis could result in the use of inappropriate or ineffective interventions.

Although behavioral problems are not universal among the DD population, many individuals with a developmental disability do show problems with impulse control, self-management of their behavior, and may have problems with mood swings, which may or may not be part of their developmental delay. The high rate of co-occurring neurological and general medical conditions can further complicate the diagnostic profile for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's developmental disability, organic brain pathology, and/or mental illness covered under the Colorado Medicaid Community Mental Health Services Program is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document has been developed by the Behavioral Health Organizations (BHOs) in collaboration with Community Center Boards (CCBs), developmental disability professionals, consumer advocates and other key stakeholders, in the interest of fulfilling their responsibilities under the Colorado Medicaid Community Mental Health Services Program, and to meet the BHO/HCPF contract requirement, which states, "The Contractor [BHO] shall develop written criteria for determining whether the need for mental health services for a Medicaid recipient with co-occurring mental illness and developmental Disabilities is a result of the individual's mental illness, or a result of the individual's developmental Disability…The criteria shall be approved by the Department." The document is an attempt to define these criteria for use by evaluating clinicians. It is not intended to fully describe the collaboration between providers, BHOs and CCBs, that is both required and embraced as values (and in most cases as a reality) by those organizations, by families, and by advocates for individuals with DD/MI. The Colorado BHOs have adopted the following Practice Standards for their Medicaid recipients with a developmental disability:

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1. In no circumstance, does the presence of DD preclude an assessment for co-occurring mental illness covered under the Colorado Medicaid Community Mental Health Services Program. BHOs and their contracted providers will not deny services for a covered diagnosis on the basis of that covered diagnosis not being primary. The presence of a covered diagnosis and the BHO's determination that the issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A BHO provider will complete a face-to-face assessment on any child, youth, or adult with DD who is referred for evaluation for covered mental illness according to that BHO's regular intake and admission procedures and standards. The BHO will provide a mental health assessment for any child, youth or adult with a developmental disability who is referred for evaluation of a covered mental illness. For consumers whose developmental disability and/or level of functioning precludes the use of standard evaluation protocols, the BHO will solicit the participation and/or assistance from someone, such as the CCB case manager, or family member, who can provide information needed to conduct the assessment. Evaluations will be conducted in a secure setting to ensure the safety of a consumer who is behaviorally out of control.

3. The BHO will complete a new face-to-face assessment on any re-referred consumer in which its last assessment is greater than 120 days old.

4. In the specific circumstance in which a BHO provider has assessed a consumer with DD within the past 120 days and services have been denied, and the consumer is re-referred for another assessment within that 120-day window, the BHO will re-assess whether there has either been a change in the consumer's mental status or if new and relevant information have been provided.

5. Referral for evaluation of Medicaid recipients with DD can be made 24 hours a day, 7 days a week through the BHO's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the BHO. Emergency referrals may be evaluated either within a BHO network site or by BHO staff in a hospital Emergency Department or other safe environment. After-hours emergency referrals are evaluated in a safe environment, usually in a hospital Emergency Department.

7. All evaluations during regular working hours are reviewed by an experienced licensed professional within the BHO provider network if there are diagnostic uncertainties. Any decision to deny services to a consumer with a developmental disability will be reviewed by the BHO Medical Director or physician designee. All after-hours evaluations are reviewed with the on-call psychiatrist prior to a denial being issued. In all BHOs, an initial appeal of any decision to deny a request for services requires that the denial be reviewed by another psychiatrist other than the psychiatrist who issued the first denial.

8. BHOs may also utilize courtesy evaluations from other BHOs, and/or delegate emergency assessment to hospital emergency department personnel for Medicaid recipients requiring assessment outside their network areas. If treatment is medically necessary (as defined in item #9

below) outside the network area, the BHO will negotiate a single-case agreement or other non-network arrangement with a qualified provider to deliver that medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Colorado Medicaid Community Mental Health Services Program; and, evidence that the referring symptoms are associated with that covered mental illness, that treatment of the symptoms is medically necessary, and that it is provided within the least restrictive environment.

10. Services may be authorized either in whole or in part based upon the relative contribution of covered and non-covered (DD and/or organic brain pathology) conditions, and any collaborative arrangements in place between the BHO and the CCB involved with the individual.

11. At the time of evaluation, the BHO will review all relevant and available information including records of past diagnoses and treatments; however, the BHO will evaluate the provider's diagnostic formulation based on the preponderance of the medical evidence available at the time. If there is not adequate evidence available upon which to accept or challenge the diagnostic formulation of the provider, the BHO may defer its final authorization decision until sufficient information has been received. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

12. Cases in which the BHO evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary, the consumer, family member, CCB Case Manager and/or authorized representative will be given detailed written information, in accordance with HIPAA regulations, about the clinical rationale for the denial as well as information about all available appeal rights and assistance with filing an appeal through the BHO.

14. The BHOs acknowledge that diagnosis often "evolves" over a period of time as the natural progression of a disorder further defines itself; and, as new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In all situations in which the provider changes a previous diagnostic formulation, they will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the BHO Medical Director will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the BHO contract is the DSM-5 criteria for that diagnosis. BHOs follow conventional diagnostic practice in considering whether DSM-5 criteria are met, and consider that DSM-5 symptomatology may present atypically in individuals with a developmental disability. However, a DSM-5 diagnosis

cannot be made in the absence of reasonably meeting such criteria in the context of an atypical presentation. Diagnostic evaluations will include a review of prior treatment and evaluations, past and current response to prescribed medications, and past and current behavioral presentation as described by care providers, family members and other information sources.

2. Other diagnoses, including the developmental disability, must be present to explain variances from DSM-5 criteria.

3. Consideration is given to the consumer's abilities or disabilities in how DSM-5 criteria present themselves. The diagnostic process must be developmentally sensitive.

4. Additional diagnoses will not be considered in authorizing services when other known and clearly documented diagnoses sufficiently explain the clinical presentation of the consumer.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the consumer, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the consumer, and are provided in the least restrictive setting where services can safely be provided.

7. BHO Medicaid recipients with developmental disability have access to the full spectrum of appeal rights under the Colorado Medicaid Community Mental Health Services Program for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary.

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BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI).

People with traumatic brain injuries should be given the same access to mental health services as the general Medicaid population. The intent of this document is to make sure that a diagnosis of traumatic brain injury does not preclude an individual from receiving a diagnosis and treatment of a covered mental illness, if appropriate. As with any other population, individuals with TBI are at risk for increased symptoms, impairment, and disability without accurate assessment and appropriate treatment.

Although behavioral problems are not universal in the TBI population, many individuals with a TBI do experience problems with impulse control and self-management of their behavior. Clients may have problems with mood swings, depression, anxiety and psychosis. These problems can be related to the traumatic brain injury, reactive psychological processes and/or co-occurring mental illness diagnoses.

The high rate of co-occurring general medical conditions can further complicate the diagnostic profile and management for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's organic brain pathology, and/or mental illness covered under the Colorado Medicaid Community Mental Health Services Program is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document has been developed by several organizations with experience in this area. They include Behavioral Health Organizations (BHOs), the Department of Health Care Policy and Financing, traumatic brain injury treatment professionals, consumer advocates and other key stakeholders.

This document attempts to define criteria for service access and appropriate billing (capitation vs. fee for service) for use by evaluating clinicians and BHO/Community Mental Health Center (CMHC) administrators. It is not intended to fully describe the collaboration between providers, or between BHOs and other providers. All contributors to this document, including family members and advocates, embrace the value of systems working together.

The Colorado BHOs have adopted the following Practice Standards for Medicaid recipients with a traumatic brain injury:

1. Under no circumstance does the presence of TBI preclude an assessment for and treatment of co-occurring mental illness covered under the Colorado Medicaid Community Mental Health Services Program. BHOs will not deny services for a covered diagnosis on the basis that the covered diagnosis is not primary, and regardless of etiology. For example, a client presenting with post-traumatic stress disorder which developed as a result of a brain injury will be treated

for the PTSD, regardless of whether or not the PTSD was caused from incident in which the brain injury occurred. The presence of a covered diagnosis and the BHO's determination that the issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A BHO provider will complete a face-to-face assessment with any child, youth, or adult with TBI who is referred for evaluation for covered mental illness according to the provider's regular intake and admission procedures and standards. For clients whose traumatic brain injury or level of functioning does not allow for the use of standard assessment procedures, the BHO will request needed information from other sources such as the client's providers, case manager, or family member when available. When these resources are not available, the BHO shall consult outside professionals with expertise in brain injury.

3. The BHO will ensure assessment on any re-referred client for whom the last assessment is older than 120 days.

4. If a consumer is referred for a second assessment within 120 days of being denied services as a result of the determination that their symptoms are not covered under the current contract, the BHO will consider the following when determining medical necessity:

a. There has been a change in the consumer's mental status, or

b. New and relevant information has been provided.

If so, the BHO will arrange for another mental health assessment based on the new information and/or mental status changes reported.

5. Referral for evaluation of Medicaid recipients with TBI can be made 24 hours a day, 7 days a week through the BHO's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the BHO. Emergency referrals may be evaluated either within a BHO network site or by BHO staff in a hospital Emergency Department or other safe environment. After hours emergency referrals are to be evaluated in a safe environment, usually in a hospital Emergency Department. BHO providers shall make reasonable efforts to contract with an expert in TBI in order to provide consultation.

7. If there are diagnostic uncertainties, all evaluations during regular working hours are reviewed by an experienced licensed professional within the BHO provider network. Any decision to deny services to a consumer with a traumatic brain injury will be reviewed by the BHO Medical Director or physician designee. All after hours evaluations will be reviewed with the on-call psychiatrist prior to a denial being issued. In addition, BHO policy dictates that an initial appeal of any decision to deny a request for services requires that the denial be reviewed by a psychiatrist other than the psychiatrist who issued the first denial.

8. BHOs may utilize courtesy emergency evaluations from other BHOs. BHOs may also utilize hospital emergency department personnel to conduct an evaluation on a client outside the network area. If treatment is medically necessary (as defined in item #9 below) outside the network area, the BHO will negotiate an arrangement with a qualified provider to deliver the medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Colorado Medicaid Community Mental Health Services Program. Evidence that the referring symptoms are associated with that covered mental illness, evidence that treatment of the symptoms is medically necessary, and an assurance that treatment is provided within the least restrictive environment is necessary. The HCPF document, labeled "Exhibit D – Covered Diagnoses" from the 2009 contract accompanies this document and is available from HCPF or any BHO.

10. Services may be authorized either in whole or in part based upon determination of the underlying cause of the symptoms presented at the time. If it is determined that the individual does not have a covered diagnosis, the BHO will refer the individual to a specialist provider covered under the Medicaid fee for service program.

11. At the time of evaluation, the BHO will review all relevant and available information including records of past diagnoses and treatments. However, the BHO does not recognize "by history" diagnoses and will evaluate the provider's diagnostic formulation based on the prevalence of the medical evidence available at the time. If there is not enough evidence available to accept or challenge the diagnostic formulation of the provider, the BHO may defer its final authorization decision until sufficient information has been received. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

12. Cases in which the BHO evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary or not covered by the BHO, the consumer, family member, Case Manager and/or authorized representative will be given detailed written information about the clinical rationale for the denial. The BHO will also provide information about all available appeal rights and assistance with filing an appeal through the BHO.

14. The BHOs acknowledge that diagnoses often "evolve" over a period of time as the natural progression of a disorder further defines itself. Often, new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In situations in which the provider changes a previous diagnostic formulation, the provider will clearly document both the

clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the BHO Medical Director or physician designee will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the BHO contract is the DSM-5 criteria for that diagnosis. While currently the ICD-10 is the standard by which diagnoses are coded for billing and reporting purposes, the DSM-5 remains the clinical standard by which diagnostic criteria are met and diagnoses are established. DSM-5 criteria must be met to support diagnoses even though billing and reporting will ultimately be submitted under ICD-10 codes. BHO contracted providers follow conventional diagnostic practice in considering whether diagnostic criteria are met, and consider that symptomatology may present atypically in individuals with a TBI. However, a diagnosis cannot be made in the absence of reasonably meeting criteria even in the context of an atypical presentation. Diagnostic evaluations will include a review of preexisting conditions, premorbid functioning, family medical and psychiatric history, prior treatment and evaluations, past and current response to treatment including prescribed medications, and past and current symptomatology and behavioral presentation as described by the individual, care providers, family members and other information sources.

2. Other diagnoses, including the traumatic brain injury, must be present to explain variances from diagnostic criteria.

3. Consideration is given to the consumer's abilities or disabilities in how diagnostic criteria present themselves.

4. Upon completion of a diagnostic evaluation as described in Guiding Principle #1, if a specific diagnosis is established with a reasonable degree of certainty, additional diagnoses will not be considered in authorizing services.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the consumer, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the consumer, and are provided in the least restrictive setting where services can safely be provided.

7. BHO Medicaid recipients with traumatic brain injury have access to the full spectrum of appeal rights under the Colorado Medicaid Community Mental Health Services Program for

adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary. Future review could involve expanding these guidelines.