MAGELLAN BEHAVIORAL HEALTH, INC.

Medical Necessity Criteria Guidelines 2013

Effective Date: January 1, 2013

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Preamble- Principles of Medical Necessity Determinations

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan Behavioral Health* is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual patient's biopsychosocial needs. We see the continuum of care as a fluid treatment pathway, where patients may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate.[Q3] At any level of care, such treatment is individualized, active and takes into consideration the patient's stage of readiness to change/readiness to participate in treatment.[Q1, Q2]

The level of care criteria that follow are guidelines for determining medical necessity for DSM-IV-TR disorders. Individuals may at times seek admission to clinical services for reasons other than medical necessity, e.g., to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway/truant behavior, to achieve family respite, etc. However, these factors do not alone determine a medical necessity decision. Further, coverage for services is subject to the limitations and conditions of the member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which medical necessity criteria are applicable.

Although these Medical Necessity Criteria Guidelines are divided into "psychiatric" and "substance-related" sets to address the patient's primary problem requiring each level of care, psychiatric and substance-related disorders are often co-morbid. Thus, it is very important for all treatment facilities and providers to be able to assess these co-morbidities and address them along with the primary problem.[J4,R7,R15]

Clinical Judgment and Exceptions

The Magellan Behavioral Health Medical Necessity Criteria Guidelines direct both providers and reviewers to the most appropriate level of care for a patient. While these criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. As in the review of non-exceptional cases, clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases.

All medical necessity decisions about proposed admission and/or treatment, other than outpatient, are made by the reviewer after receiving a sufficient description of the current clinical features of the patient's condition that have been gathered from a face-to-face evaluation of the patient by a qualified clinician. Medical necessity decisions about each patient are based on the clinical features of the individual patient relative to the patient's socio-cultural environment, the medical necessity criteria, and the real resources available. We recognize that a full array of services is not available everywhere. When a medically necessary level does not exist (e.g., rural locations), we will support the patient through extra-contractual benefits, or we will authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the patient's essential needs for safe and effective treatment.

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Medical Necessity Definition

Magellan reviews mental health and substance abuse treatment for medical necessity. Magellan defines medical necessity as:

"Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

1. *consistent with:*
    a. *the diagnosis and treatment of a condition; and*
    b. *the standards of good medical practice;*
2. *required for other than convenience; and*
3. *the most appropriate supply or level of service.*

When applied to inpatient care, the term means: the needed care can only be safely given on an inpatient basis."

Each criteria set, within each level of care category (see below) is a more detailed elaboration of the above definition for the purposes of establishing medical necessity for these health care services. Each set is characterized by admission and continued stay criteria. The admission criteria are further delineated by severity of need and intensity and quality of service.

Particular rules in each criteria set apply in guiding a provider or reviewer to a medically necessary level of care (please note the possibility and consideration of exceptional patient situations described in the preamble when these rules may not apply). For admission, both the severity of need and the intensity and quality of service criteria must be met. The continued stay of a patient at a particular level of care requires the continued stay criteria to be met (Note: this often requires that the admission criteria are still fulfilled). Specific rules for the admission and continued stay groupings are noted within the criteria sets.

Levels of Care & Service Definitions

Magellan believes that optimal, high-quality care is best delivered when patients receive care that meets their needs in the least-intensive, least-restrictive setting possible. Magellan's philosophy is to endorse care that is safe and effective, and that maximizes the patient's independence in daily activity and functioning.

Magellan has defined eight levels of care as detailed below. These levels of care may be further qualified by the distinct needs of certain populations who frequently require behavioral health services. Children, adolescents, geriatric adults and those with substance use and eating disorders often have special concerns not present in adults with mental health disorders alone. In particular, special issues related to family/support system involvement, physical symptoms, medical conditions and social supports may apply. More specific criteria sets in certain of the level of care definitions address these population issues.

The eight levels of care definitions are:

1. Hospitalization

   Hospitalization describes the highest level of skilled psychiatric and substance abuse services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general hospital or a detoxification unit in a hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care[1].

   This definition also includes crisis beds, hospital-level rehabilitation beds for substance use disorders and 23-hour beds that provide a similar, if not greater, intensity of medical and nursing care[1]. For crisis and 23-hour programs, the psychiatric hospitalization criteria apply for medical necessity reviews. For hospital-level substance abuse rehabilitation, the Hospitalization, Rehabilitation Treatment, Substance Use Disorder criteria set applies. For subacute hospitalization, the Hospitalization, Subacute criteria set applies.

2. Subacute Hospitalization

   The subacute hospital level of care is designed to meet the needs of a patient with mental health problems that require an inpatient setting due to potential for harm to self or to others or potential for harm to self due to an inability to adequately care for his/her personal needs without presenting an imminent threat to himself/herself or to others.

   The purpose of subacute care programs is to provide rehabilitation and recovery services and to assist in a patient's return to baseline function and transition back into the community. Subacute care programs serve patients who require less-intensive care than traditional acute hospital care, but more intensive care than residential treatment. Typically, length of stay for subacute is longer than acute hospitalization, but shorter than residential. Twenty-four hour monitoring and supervision by a multidisciplinary behavioral health treatment team provide a safe and effective treatment environment.

   Patients in this setting should have adequate impulse control and the ability to cooperate with staff to communicate effectively and accomplish the tasks of daily living with minimal support. Treatment includes daily psychiatric nursing evaluation and intervention, direct services at least three times weekly, direct services by a psychiatrist (including medication management), psychotherapy and social interventions in a structured therapeutic setting. Psychiatric and medical services are available 24-hours a day, seven days a week in the case of emergencies. When indicated (and especially for children and adolescents), families and/or guardians are involved in the treatment process. Patients are ready for discharge from this level of care when they show good impulse

[1] Magellan Medical Necessity criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

control, medication compliance, effective communication and the ability to accomplish activities of daily living consistent with their developmental capabilities. Subacute is usually provided as a step-down from acute hospitalization.

3. 23-Hour Observation

   The main objective of 23-hour observation is to promptly evaluate and stabilize individuals presenting in a crisis situation. This level of care provides up to 23 hours and 59 minutes of observation and crisis stabilization, as needed. Care occurs in a secure and protected environment staffed with appropriate medical and clinical personnel, including psychiatric supervision and 24-hour nursing coverage.

   Aspects of care include a comprehensive assessment and the development and delivery of a treatment plan. The treatment plan should emphasize crisis intervention services intended to stabilize and restore the individual to a level of functioning that does not necessitate hospitalization. In addition, 23-hour observation may be used to complete an evaluation to determine diagnostic clarification to establish the appropriate level of care. As soon as the risk level is determined, diagnostic clarity is established, and/or crisis stabilization has been achieved, appropriate referral and linkage to follow-up services will occur.

   If clinical history or initial presentation suggested that the individual required a secure and protected inpatient level of care for more than 23 hours and 59 minutes, this level of care would not be appropriate.

4. Residential Treatment

   Residential Treatment is defined as a 24-hour level of care that provides persons with long-term or severe mental disorders and persons with substance-related disorders with residential care. This care is medically monitored, with 24-hour medical and nursing services availability. Residential care typically provides less intensive medical monitoring than subacute hospitalization care. Residential care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient. Residential treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care. Settings that are eligible for this level of care are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level of care may vary by state.

5. Supervised Living

   Supervised Living for substance-related disorders includes community-based residential detoxification programs, community-based residential rehabilitation in halfway and quarterway houses, group homes, specialized foster care homes which serve a limited number of individuals in community-based, home-like settings, and other residential settings which require abstinence.

   Supervised Living for mentally ill individuals includes community residential crisis intervention units, supervised apartments, halfway houses, group homes, foster care that serves a limited number of individuals (e.g., group homes generally serve up to eight; foster care homes generally serve one or two) in community-based, home-like settings, and other residential settings which provide supervision and other specialized custodial services.

   This level of care combines outpatient treatment on an individual, group and/or family basis (usually provided by outside practitioners) with assistance and supervision in managing basic day-to-day activities and responsibilities outside the patient's home. These settings are often licensed as halfway houses or group homes depending on the state.

6. Partial Hospitalization

   These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least 4 hours/day and are available at least 3 days/week. The services include medical and nursing[2], but at less intensity than that provided in a hospital setting. The patient is not considered a resident at the program. The range of services offered is designed to address a mental health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

7. Intensive Outpatient Programs

   Intensive outpatient programs are defined as having the capacity for planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment." (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge).

8. Outpatient Treatment

   Outpatient treatment is typically individual, family and/or group psychotherapy, and consultative services (including nursing home consultation). Times for provision of these service episodes range from fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

[2] Magellan Medical Necessity criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

Term Definitions

1. Family:

   Individuals identified by an adult as part of his/her family or identified by a legal guardian on behalf of children. Examples would include parents/step-parents, children, siblings, extended family members, guardians, or other caregivers.

2. Support System:

   A network of personal (natural) or professional contacts available to a person for practical, clinical, or moral support when needed. Examples of personal or natural contacts would include friends, church, school, work and neighbors. Professional contacts would include primary care physician, psychiatrist, psychotherapist, treatment programs (such as clubhouse, psychiatric rehabilitation), peer specialists, and community or state agencies.

3. Significant Improvement:

   a) Services provided at any level of care must reasonably be expected to improve the patient's condition in a meaningful and measurable manner. The expectation is that the patient can accomplish the following in the current treatment setting: continue to make measurable progress, as demonstrated by a further reduction in psychiatric symptoms, or
   b) acquire requisite strengths in order to be discharged or move to a less restrictive level of care.

   The treatment must, at a minimum, be designed to alleviate or manage the patient's psychiatric symptoms so as to prevent relapse or a move to a more restrictive level of care, while improving or maintaining the patient's level of functioning. "Significant Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require a move to a more restrictive level of care, this criterion would be met.

   For most patients, the goal of therapy is restoration to the level of functioning exhibited prior to the onset of the illness. For other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable interpretation of "significant improvement."

Hospitalization, Psychiatric, Adult

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B and one of C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:

   1) a current plan or intent to harm self with an available and lethal means, *or*
   2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
   3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
   4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

   1) a current plan or intent to harm others with an available and lethal means, *or*
   2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
   3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
   4) other similarly clear and reasonable evidence of imminent serious harm to others.

E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.[H11]

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.W2 Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the patient's family and/or other support systems, unless there is an identified, valid reason why it is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.H2, H39, H48

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources. H3, H15

Hospitalization, Psychiatric, Child and Adolescent[3]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B, and one of C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:

1) a current plan or intent to harm self with an available and lethal means, *or*
2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

1) a current plan or intent to harm others with an available and lethal means, *or*
2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
4) other similarly clear and reasonable evidence of imminent serious harm to others.

[3] Experts generally agree that no one chronological age defines the end of adolescence. Rather, it is determined by considering a number of factors including chronological age, maturity, school and social status, family relationships, and living situation. For purposes of consistency, it is suggested that child and adolescent criteria sets be applied to individuals 17 years of age or younger.

E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. The individualized plan of treatment includes plans for at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

E. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.[W3] This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.[I2]

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

Hospitalization, Psychiatric, Geriatric[4]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B, and one of C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:

   1) a current plan or intent to harm self with an available and lethal means, *or*
   2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
   3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
   4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

   1) a current plan or intent to harm others with an available and lethal means, *or*
   2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
   3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
   4) other similarly clear and reasonable evidence of imminent serious harm to others.

[4] These criteria apply to those individuals at or over the age of 65.

E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. As part of the mental status testing, assessment of cognitive functioning is warranted. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living[5], other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

[5] Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with caretakers/guardians/family members, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.[G46]

Hospitalization, Eating Disorders[6]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and one of criteria B, C, D or E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The illness can be expected to improve and/or not worsen through medically necessary and appropriate therapy, by accepted medical standards. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorders hospital level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.

B. One of the following:

1) the adult patient has physiologic instability that may include but is not limited to: disturbances in heart rate, blood pressure, glucose, potassium, electrolyte balance, temperature, and hydration; clinically significant compromise in liver, kidney, or cardiovascular function; and/or poorly controlled diabetes.F3

2) the child or adolescent patient has physiologic instability that may include but is not limited to: disturbances in heart rate or blood pressure, including orthostatic blood pressure changes; hypokalemia, hypophosphatemia, or hypomagnesemia.F3

3) while admission to this level of care is primarily based on presence of physiologic instability, generally, patients with a body weight significantly below ideal, e.g., 75% of Ideal Body Weight (IBW) or less, or Body Mass Index (BMI) of 16 or below, will have physiologic instability as described above. However, if body weight is equal to or greater than 75% of IBW (or BMI greater than 16), Criterion B can be met if there is evidence of any one of the following:

a) weight loss or fluctuation of greater than 15% in the last 30 days, *or*

b) weight loss associated with physiologic instability unexplained by any other medical condition, *or*

c) the patient rapidly approaching a weight at which physiologic instability occurred in the past, *or*

d) a child or adolescent patient having a body weight less than 85% of IBW during a period of rapid growth.

C. In anorexia, the patient's malnourished condition requires 24-hour medical/nursing intervention to provide immediate interruption of the food restriction, excessive exercise, purging and/or use of laxatives/diet pills/diuretics[F13] to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious

[6] Because of the severity of co-existing medical disorders, the principal or primary treatment of some eating disorders may be medical/surgical. In these instances, medical/surgical benefits and criteria for appropriateness of care will apply.

complications to a co-morbid medical condition or psychiatric condition (e.g., severe depression with suicidal ideation).

D. In patients with bulimia , the patient's condition requires 24-hour medical/nursing intervention to provide immediate interruption of the binge/purge cycle to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation).[F79]

E. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., residential or partial hospital) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in treatment, the patient must:

1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *and*
2) have physiologic instability and/or significant weight loss (generally, less than 85% IBW), *and*
3) have significant impairment in social or occupational functioning, *and*
4) be uncooperative with treatment (or cooperative only in a highly structured environment), *and*
5) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the eating disorder diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. This psychiatric evaluation should also assess for co-morbid psychiatric disorders, and if present, these should be addressed in the treatment plan. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment including but not limited to medication monitoring and administration, nutritional services, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.[F13] Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

C. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and either E or F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

E. The patient's weight remains less than 85% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.

F. There is evidence of a continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required.

Hospitalization, Substance Use Disorders, Detoxification[7]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B must be met to satisfy the criteria for severity of need.

A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.

B. Detoxification at a lesser intensive level of care and/or the utilization of an organized support system would potentially be unsafe as evidenced by one of the following:

1) the patient presents with either:

a) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*

b) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances.

or

2) the patient presents with co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission.

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This staffing must provide 24-hour services, including skilled observation and medication administration.

C. Documentation of blood and/or urine drug screen is ordered upon admission.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

[7] It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

G. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Based on admission criteria the patient continues to need inpatient medical monitoring and treatment.

B. There are continued physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.

C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-hospitalization treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent[D2, D5]

Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for severity of need.

A. The patient has a substance use disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to an inpatient substance rehabilitation treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. The patient's need for detoxification treatment is not of a severity to require a hospital level of detoxification care.

E. One of the following must be met to satisfy this criterion:

1) despite recent (i.e., the past 3 months) appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective outpatient rehabilitation treatment at a less-intense level of care, and alternative living situations are not available or clinically appropriate.

F. One of the following must be met:

1) due to continued abuse of substance(s), the patient is not able to adequately care for a co-morbid medical condition(s) that require(s) medical monitoring or treatment; *or*

2) the patient is in need of substance use disorder rehabilitation treatment and has a co-morbid medical condition(s) that currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.

G. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. The program must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services to monitor the co-morbid medical condition(s) and any ancillary detoxification needs, to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live substance-free outside of a hospital rehabilitation setting.

C. An individualized plan of active behavioral health treatment is provided. This plan must include intensive individual, group and family education and therapy in a hospital rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the physician at least on a daily basis. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospital treatment needs. This plan will include linkage to outpatient primary care.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of at least regular family and/or support system involvement as indicated to promote a successful continuum of less-intense services post discharge, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.

Hospitalization, Substance Use Disorders, Rehabilitation Treatment, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for severity of need.

A. The patient has a substance use disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to an inpatient substance rehabilitation treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. The patient's need for detoxification treatment is not of a severity to require a hospital level of detoxification care.

E. One of the following must be met to satisfy this criterion:

1) despite recent (i.e., the past 3 months) appropriate, professional intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intense level of care, and alternative living situations are not available or clinically appropriate.

F. One of the following must be met:

1) due to continued abuse of substance(s), the patient is not able to adequately care for a substance-related, acute, co-morbid medical condition(s) that require(s) medical monitoring or treatment; *or*

2) the patient is in need of substance use disorder rehabilitation treatment and has a substance-related, acute, co-morbid medical condition(s) that currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.

G. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. An appropriate initial medical assessment and ongoing medical management must be available to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. The program must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services to monitor the co-morbid medical condition(s), to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live substance-free outside of a hospital rehabilitation setting.

C. An individualized plan of active behavioral health treatment is provided. This plan must include intensive individual, group and family education and therapy in a hospital rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

   1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

   2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

   3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the physician at least on a daily basis. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospital treatment needs. This plan will include linkage to outpatient primary care.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of regular family and/or support system involvement as indicated to promote a successful continuum of less-intense services post discharge, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

Subacute Hospitalization, Psychiatric, Adult

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) at least three-times-a-week psychiatric reassessments, *and*

3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

4) evaluation for current medical problems, *and*

5) evaluation for concomitant substance use issues, *and*

6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

Subacute Hospitalization, Psychiatric, Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include, but is not limited to: medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living[8], other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission. As part of the mental status testing, assessment of cognitive functioning is warranted.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

[8] Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) at least three-times-a-week psychiatric reassessments, *and*

3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

4) evaluation for current medical problems, *and*

5) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*

6) evaluation for concomitant substance use issues, *and*

7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his or her regular social environment as soon as possible, unless contraindicated.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.

E. There is evidence of at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate treatment resources after the subacute hospitalization.

Subacute Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly family and/or other support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) at least three-times-a-week psychiatric reassessments, *and*

3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

4) evaluation for current medical problems, *and*

5) evaluation for concomitant substance use issues, *and*

6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the provider.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

23-Hour Observation

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected psychiatric and/or substance use disorder. A psychiatric and/or substance use disorder is defined as a disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable Axes (I-V). There may be a lack of a primary definitive DSM-IV-TR diagnosis and/or an incomplete understanding of the patient's clinical needs due to a lack of clinical information or an evolving clinical condition (e.g., intoxication) in which an extended observation period is medically necessary in order to establish a primary, definitive DSM-IV-TR and subsequent treatment plan.

B. Based on the potential risk to self or others, the patient requires an individual plan of extended observation, acute medical and therapeutic crisis intervention and continuity of care services in a facility setting with medical staffing, psychiatric supervision and continuing nursing evaluation. The 23-hour observation must provide immediate services in a facility setting that may include, but are not limited to, diagnostic clarification, assessment of needs, medication monitoring and administration, individual therapy, family and/or other support system involvement, and suicidal/homicidal observation and precautions as needed.

C. Although there is evidence of a potential or current mental health or substance abuse emergency based on history or initial clinical presentation, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is not clearly indicated.

D. The patient must be medically stable, or there must be appropriate medical services to monitor and treat any active medical condition.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. Acute care nursing, medication management and monitoring are available, and all appropriate drug screens, laboratory studies, and medical testing are considered in accordance with accepted medical practice and clinical practice guidelines.

B. A comprehensive evaluation administered by a psychiatrist, which includes a biopsychosocial assessment (based on the available information), mental status examination, and physical examination is completed and appropriate treatment and disposition recommendations are developed.

C. Clinical interventions emphasize crisis intervention, relapse prevention and motivational strategies with the intent to stabilize the patient and enhance motivation for change utilizing medication management, individual therapy and/or family or other support system involvement (the frequency of which will be determined by what the

treatment team believes is needed to stabilize and re-evaluate the patient) with focus on proximal events in a brief solution-focused model.

D. Consultation services are available for general medical, pharmacology and psychological services.

E. Outpatient treatment providers and/or primary care physicians are consulted during the observation period as clinically indicated (and with the patient's documented consent).

F. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in the admission to a 23-hour observation bed, and this discharge plan begins to identify appropriate treatment resources following discharge. Reasonable attempts are made to coordinate the treatment and affect a timely disposition plan in collaboration with current treatment providers.

Criteria for Continued Stay

None

Criteria for Discharge

Criteria A or B must be met to satisfy criteria for discharge:

A. The patient meets admission criteria for inpatient hospitalization.

B. The patient no longer meets admission criteria and can be safely and effectively treated at a less-intensive and restrictive level of care.

Residential Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential setting.

E. The patient's current living environment does not provide the support and access to therapeutic services needed.

F. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation. With the geriatric patient, cognitive functioning is warranted as part of the mental status testing assessment.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*

2) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

3) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*

4) evaluation for concomitant substance use issues, *and*

5) integrated treatment, rehabilitation and support provided by a multidisciplinary team, *and*

6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.

E. There is evidence of weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential setting.

E. The patient's current living environment does not provide the support and access to therapeutic services needed.

F. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible, *and*

2) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*

3) evaluation for current medical problems, *and*

4) evaluation for concomitant substance use issues, *and*

5) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.

E. There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

If patient has anorexia, criteria A B, C, D, E and F must be met to satisfy the criteria for severity of need. If patient has bulimia or Eating Disorder Not Otherwise Specified, criteria A, B, C, D and G must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorder residential level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.

B. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

C. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., partial hospital or intensive outpatient) *or* there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in a less-intensive setting than residential, the patient must:

   1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *and*

   2) have significant impairment in social or occupational functioning, *and*

   3) be uncooperative with treatment (or cooperative only in a highly structured environment), *and*

   4) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

D. The patient's current living environment has severe family conflict and/or does not provide the support and access to therapeutic services needed. Specifically there is evidence that the patient needs a highly structured environment with supervision at or between all meals or will restrict eating or binge/purge. Additionally, the family/support system cannot provide this level of supervision along with a less-intensive level of care setting.

E. If a patient has anorexia, and has a body weight less than 85% of Ideal Body Weight (IBW).[F3] If body weight is equal to or greater than 85% of IBW, this criterion can be met if there is evidence of any one of the following:

   1) weight loss or fluctuation of greater than 10% in the last 30 days, *or*

   2) the patient is within 5-10 pounds of a weight at which physiologic instability occurred in the past, *or*

   3) a child or adolescent patient rapidly losing weight and approaching 85% of IBW during a period of rapid growth.

F. In anorexia, the patient's malnourished condition requires 24-hour residential staff intervention to provide interruption of the food restriction, excessive exercise, purging, and/or use of laxatives/diet pills/diuretics to avoid imminent further weight loss or to continue weight gain from a recent hospital level care.

G. In patients with bulimia or eating disorder not otherwise specified, the patient's condition requires 24-hour residential staff intervention to provide interruption of the binge and/or purge cycle to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation).

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family members and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of internal controls to prevent excessive food restricting, binging, purging, exercising and/or use of laxatives/diet pills/diuretics. The program also assists with planning and arranging access to a range of educational, therapeutic and aftercare services and assists with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:

1) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
2) psychotropic medications, if medically indicated, to be used with specific target symptoms identified, *and*
3) evaluation and management for current medical problems, *and*
4) evaluation and treatment for concomitant substance use issues, *and*
5) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for continued stay. Additionally, if anorectic, criterion H must also be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the eating disorder behaviors and precipitating psychosocial stressors that are interfering with the patient's ability to participate in a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in daily progress notes, written and signed by the provider.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. There is evidence of a continued inability to adhere to a meal plan and maintain control over restricting of food or urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required.

G. A discharge plan is formulated that is directly linked to the eating behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

H. If anorectic, the patient's weight remains less than 85% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.

Residential Treatment, Substance Use Disorders, Detoxification[9]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, and C must be met to satisfy the criteria for severity of need.

A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.

B. Detoxification cannot be safely or effectively managed at a less-intensive level of care and/or by an organized support system.

C. Detoxification at an acute inpatient level of care is not required because the patient does not present with:

1) co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered, *or*

2) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*

3) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission.

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This staffing must provide 24-hour services, including skilled observation and medication administration.

C. Documentation of blood and/or urine drug screen is ordered upon admission.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

[9] It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, and D must be met to satisfy the criteria for continued stay.

A. Admission criteria continue to be met.

B. There are physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.

C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-residential treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.[D2, D5]

Residential Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a substance-related disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. One of the following must be met to satisfy criterion D:

1) despite recent (i.e., the past 3 months) appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intensive level of care and alternative living situations are not available or clinically appropriate, *or*

3) there is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in a less-intensive setting.

E. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face behavioral health evaluation. With the geriatric patient, cognitive functioning is warranted as part of the mental status testing assessment.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic

and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. Additionally, there is sufficient availability of medical and nursing services to manage this patient's ancillary co-morbid medical conditions.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular reviews and revisions that include ongoing plans for timely access to treatment resources that will meet the patient's post--residential treatment needs.

C. There is evidence of regular caretakers'/guardians'/family members' involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a substance-related disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.

B. The patient has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.

C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. One of the following must be met to satisfy criterion D:

1) despite recent (i.e., the past 3 months), appropriate, professional intervention, at a less-intensive level of care the patient is continually unable to maintain abstinence and recovery, *or*

2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment and alternative living situations are not available or clinically appropriate, *or*

3) there is actual evidence for, or clear and reasonable inference of serious, imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in an outpatient setting.

E. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face behavioral health evaluation.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

C. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.

C. The individual plan of active treatment includes regular family and/or support system involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Supervised Living, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of a mental illness which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective coping skills necessary to live safely in the community, participate in self-care and treatment and manage the effects of his/her illness. As a result of the patient's clinical condition (impaired judgment, behavior control, or role functioning) there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current course of illness or by the past history of illness, *or*

   2) harm to self or others as a result of the mental illness and as evidenced by the current behavior or by the past history.

C. The patient's own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced by one of the following:

   1) the patient has no residence and no social support, *or*

   2) the patient has a current residential placement, but the existing placement does not provide adequate supervision to ensure safety and participation in treatment, *or*

   3) the patient has a current residential placement, but the patient is unable to use the relationships in the existing residence to ensure safety and participation in treatment or the relationships are dysfunctional and undermine the stability of treatment.

D. The patient is judged to be medically stable, able to reliably cooperate with the rules and supervision provided, and to reliably plan for safety in the supervised residence.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic

interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. At least one responsible staff person must be present or available by telephone at all times when there are patients on the premises.

C. There is the provision of, or coordination with, medical and/or nursing services sufficient to manage this patient's co-morbid medical conditions.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of a mental illness, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. There continues to be a risk of one of the following:

1) inpatient admission, *or*

2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-supervised living, community-based treatment resources.

Supervised Living, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of an emotional/psychiatric disturbance and/or significant behavioral problem which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in a supportive home environment in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective, coping skills necessary to live safely in the community, participate in self-care and treatment and manage the effects of his/her illness. The patient's family or caregivers demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs. As a result of the patient's behavioral problems and/or functional deficits and the family's and/or support system's inability to provide adequate care and supervision of the patient to ensure his/her safety, there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current course of the disorder or by the past history of the disorder, *or*

   2) harm to self or others as a result of mental illness as evidenced by the current behavior or by the past history.

C. The patient's home environment, family resources and support network are not adequate to provide the level of residential support and supervision currently needed by the patient.

D. The patient is judged to be able to reliably cooperate with the rules and supervision provided and can be safe in a supervised residence.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. At least one responsible staff person must be present at all times when there are patients on the premises.

C. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction.

After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of a psychiatric disorder, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. The patient's family or caregivers continue to demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs and, as a result, there continues to be a risk of one of the following:

   1) inpatient admission, *or*

   2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety, care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-supervised living, community-based treatment resources.

Supervised Living, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of a substance-related disorder which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective coping skills necessary to live safely in the community participate in self-care and treatment and manage the effects of his/her disorder. As a result of the patient's clinical condition (impaired judgment, behavior control, or role functioning) there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current clinical course or by the past clinical history, *or*

   2) harm to self or others as a result of the substance-related disorder as evidenced by the current behavior or by the past history.

C. The patient's own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced by one of the following:

   1) the patient has no residence and no social support, *or*

   2) the patient has a current residential placement, but the existing placement does not provide adequate supervision to ensure safety and participation in treatment, *or*

   3) the patient has a current residential placement, but the patient is unable to use the relationships in the existing residence to ensure safety and participation in treatment or the relationships are dysfunctional and undermine the stability of treatment.

D. The patient is judged to be medically stable, able to reliably cooperate with the rules and supervision provided and able to reliably plan for safety in the supervised residence.

E. The patient's need for detoxification treatment is not of a severity to require an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. There is the provision of or coordination with medical and/or nursing services sufficient to manage this patient's co-morbid medical conditions.

C. At least one responsible staff person must be present or available by telephone at all times when there are patients on the premises.

D. Treatment considers the-use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of the substance-related disorder, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. There continues to be a risk of one of the following:

1) inpatient admission, *or*

2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed to promote recovery and for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-supervised living treatment needs.

Supervised Living, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The patient has a primary DSM-IV-TR diagnosis of a substance-related disorder which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in a supportive home environment in conjunction with medically necessary treatment, rehabilitation and support.

B. The patient's condition requires residential supervision and active support to ensure the adequate, effective, coping skills necessary to live safely in the community, participate in self-care and treatment and manage the effects of his/her illness. The patient's family or caregivers demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs. As a result of the patient's behavioral problems and/or functional deficits and the family's and/or support system's inability to provide adequate care and supervision of the patient to ensure his/her safety, there is a significant current risk of one of the following:

   1) hospitalization or other inpatient care as evidenced by the current course of the disorder or by the past history of the disorder, *or*

   2) harm to self or others as a result of the substance-related disorder as evidenced by the current behavior or by the past history.

C. The patient's home environment, family resources and support systems are not adequate to provide the level of residential support and supervision currently needed by the patient.

D. The patient is judged to be medically stable, able to reliably cooperate with the rules and supervision provided, and can be safe in a supervised residence.

E. The patient's need for detoxification treatment is not of a severity to require an inpatient hospital level of care.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A and B must be met to satisfy the criteria for intensity and quality of service.

A. Supervised living will provide supervision and support in a residence outside of the patient's own home and provides needed resources and support not sufficiently available within the patient's own existing social support system. Clinical intervention services, including behavioral, psychological and psychosocial therapeutic interventions, may also be provided within supervised residential settings, in lieu of or in addition to outpatient and other community-based mental health services.

B. At least one responsible staff person must be present at all times when there are patients on the premises.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for continued stay.

A. The patient continues to have significant functional impairment as a result of the substance-related disorder, and the problems that caused the admission persist to a degree that continues to meet the admission criteria.

B. The patient's family or caregivers continue to demonstrate an inability to adequately care for the patient's physical, emotional, psychosocial and/or supervision needs and, as a result, there continues to be a risk of one of the following:

   1) inpatient admission, *or*

   2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed to promote recovery and for safety, care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

D. There is evidence of coordination between the patient's supervisor and the case manager or primary therapist, if applicable.

E. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-supervised living treatment needs.

Partial Hospitalization, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay.

C. Either:

1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*

2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally; either:

1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*

2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should include caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants' work schedules or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria f or Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay.

C. Either:

   1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*

   2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally, either:

   1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, or

   2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.W6

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for at least

weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. The individual plan of active treatment includes at least weekly family therapy and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, and D must be met to satisfy the criteria for severity of need. Additionally if anorectic, criterion E must also be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition can be expected to improve and/or not worsen through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient is believed to be capable of significantly controlling binging, excessive exercising, purging and overuse of laxatives/diet pills/diuretics outside program hours. Additionally, the patient appears reasonably able to seek professional assistance or other support when not in the partial hospital setting.

C. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

D. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., outpatient or intensive outpatient) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in treatment, the patient must:

   1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *or*

   2) be uncooperative with treatment (or cooperative only in a highly structured environment), *or*

   3) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

E. The patient has anorexia; he or she is between 75-85 percent of his or her ideal body weight (IBW) and clinical evidence indicates the patient requires a structured program— including medical monitoring and nursing supervision during and between two meals per day to gain weight and/or control eating disorder behaviors— that cannot be provided in a less-intensive outpatient setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This plan also includes plans for at least weekly family and/or support system involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. If the patient has anorexia, a specific treatment goal of this team is to help the patient gain weight and develop the capability to continue this weight gain upon returning to a less-intensive level of care. If the patient has bulimia, the goal is to help the patient develop internal controls to limit binging and purging to a degree sufficient to allow the patient to transition to a less-intensive level of care.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the physician. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

D. A discharge plan is formulated that is directly linked to the eating disorder behaviors that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-IV-TR criteria and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

B. The patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.[E11]

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. There is a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, there is sufficient availability of medical and/or nursing services to manage this patient's ancillary detoxification needs.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants work schedule or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[10]

Criteria for Continued Stay

III. Continued Stay

Criteria A .B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

[10] The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-IV-TR criteria and is mentally competent and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

B. The patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

D. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[11]

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This treatment plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. The individual plan of active treatment includes regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

E. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

[11] The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The impairment results in at least one of the following:

   1) a clear, current risk to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*

   2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*

   3) an emerging/impending risk to the safety or property of the patient or of others.

C. Either:

   1) for patients with persistent or recurrent disorders, the patient's past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others, *or*

   2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.

D. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services, and is capable of seeking professional support and/or support from caretakers/guardians/family members outside of program hours as needed.

E. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups. The treatment plan actively encourages the coordination of care among the patient's providers.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A and B must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) difficulty and/or lack of coordination of a variety of outpatient services by providers/patient/family supports necessitating use of IOP to ensure this missing component, *or*

4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The impairment results in at least one of the following:

   1) a clear, current risk to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*

   2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*

   3) an emerging/impending risk to the safety or property of the patient or of others.

C. Either:

   1) for patients with persistent or recurrent disorders, the patient's past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others, *or*

   2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.

D. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.

E. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups. The treatment plan encourages the coordination of care among the patient's providers.

D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) difficulty and/or lack of coordination of a variety of outpatient services by providers/patient/family supports necessitating use of IOP to ensure this missing component, *or*

4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. The individual plan of active treatment includes at least weekly family and/or support system involvement in therapy, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Intensive Outpatient Treatment, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need. Additionally if anorectic, criterion G must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition can be expected to improve through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The impairment from the eating disorder results in at least one of the following, which requires a more intensive and structured level of care than outpatient:

   1) a clear, current threat to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*

   2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*

   3) an emerging/impending risk to the safety or property of the patient or of others.

C. Either of the following:

   1) for patients with a persistent or recurrent eating disorder, the past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing threats to the patient's medical stability, *or*

   2) for patients with an acute eating disorder crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the eating disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient.

D. The patient requires an integrated program of dietary counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.

E. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient appears able to seek professional assistance or other support when not in the intensive outpatient setting.

F. The patient is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

G. If the patient has anorexia and there is clinical evidence that without the structure of an intensive outpatient program, there is a clear current threat to the patient's ability to maintain weight >80% of IBW and a consequent threat to the patient's current medical physiologic stability.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of dietary and exercise counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff within a structured program of treatment. One specific treatment goal of this team is helping the patient internalize better control of urges to restrict food, exercise excessively, binge, purge and/or overuse laxatives/diet pills/diuretics. If anorectic, a related goal is further solidifying the stability of weight gain and/or maintenance sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

D. Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis(es) of a substance-related disorder meeting DSM-IV-TR criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional supports and/or support from caretakers/guardians/family members outside of program hours as needed.

E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. Additionally, there is the provision of or coordination with medical and/or nursing services sufficient to manage this patient's ancillary co-morbid medical conditions.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment

team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.[1,5]

D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

E. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[12]

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

[12] The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis(es) of substance-related disorder meeting DSM-IV-TR criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.

C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.

D. The patient is able to seek professional and/or social supports outside of program hours as needed.

E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.

F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission- Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

D. A Urine Drug Screen (UDS) is considered at least once per month on a random basis, or more often as clinically warranted.[13]

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

D. The individual plan of active treatment includes at least weekly family/support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

[13]The UDS should be a standard qualitative screen. A quantitative screen may be necessary after a positive qualitative result. Lab testing is preferred over dipsticks.

Ambulatory, Substance Use Disorders, Detoxification[14]

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

A. The patient has a recent history and pattern of continuous use of substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that do they not require 24-hour access to physician and/or nurse monitoring, nor a history of medically complicated withdrawal in the past

B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:

   1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*

   2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*

   3) a CIWA-Ar score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*

   4) family and/or social support is available to assist the patient during detoxification.

C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician.

B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

C. Documentation of blood and/or urine drug screen is ordered upon commencement of treatment.

[14] It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.

E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.

F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Admission criteria continue to be met.

B. The patient's condition does not require a higher level of care.

C. Documentation of signs, symptoms and improvement in withdrawal symptoms are noted, and the treatment plan is re-evaluated and modified as medically appropriate.

D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-detoxification needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.[D2, D5]

Ambulatory, Substance Use Disorders, Buprenorphine Maintenance

It is recognized that life threatening intoxication/poisoning (i.e., endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

A. The patient has a recent history and pattern of continuous use of opioid substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that they do not require 24-hour access to physician and/or nurse monitoring, nor is there a history of medically complicated withdrawal in the past.

B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:

1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*

2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*

3) a COWS score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*

4) family and/or social support is available to assist the patient during detoxification, *and*

5) a history of at least 2 prior failed opioid detoxification experiences (where there is a return to further opioid dependence) either of institutional or personal attempts.

C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, and E must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician who carries the correct Buprenorphine DEA waiver.

B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

C. Documentation of blood and/or urine drug screen is ordered upon commencement of treatment.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs, including encouragement of member to participate in substance use disorder counseling and/or appropriate support resources, such as 12-step type formats and cognitive based formats.

E. Treatment interventions are guided by quantitative measures of withdrawal such as COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Admission criteria continue to be met.

B. The patient's condition does not require a higher level of care.

C. Documentation of signs, symptoms and improvement in steadfast opioid sobriety and abstinence with the ongoing assessment and treatment plan addressing, re-evaluating, and modified as medically appropriate to ensure continued sober success.

D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate. Use of random blood and/or urine drug screen is a component of monitoring for adherence to treatment recommendations.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-maintenance needs. This plan includes attempts to link to outpatient primary care and ongoing behavioral health counseling (addressing appropriate mental health and substance disorder needs) after obtaining patient consent).[D2, D5]

Ambulatory, Substance Use Disorders, Laboratory Screening of Drugs/Substances of Abuse

Purpose: To establish the types of laboratory assays and testing frequency that is reasonable and medically necessary for the diagnosis and treatment of a substance use disorder.

Criteria for Authorization

I. Severity of Need

Criteria A and B must be met. In addition C, D, E and/or F must be met.

A. The patient has a diagnosed or suspected substance use disorder. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).

B. Screening uses a multi-panel qualitative assay screening approach (e.g., 'Drugs of Abuse 10 Panel'[15], corresponding to CPT code 80100, 80101 and 82055 for alcohol).

C. Screenings occur upon admission to the substance use disorder rehabilitation program and at ten (10) day intervals to monitor program compliance. Testing at more frequent intervals must be accompanied by documentation of reasons of medical/clinical necessity.

D. Specific drug quantitation can be performed only when there is an acute change in medical status or drug toxicity must be ruled out.

E. Quantitative testing of serum methadone levels may be performed only under the following circumstances:

1) patient is in stabilization phase and requesting an increase over 80mg of methadone, *or*

2) a patient is in maintenance phase and requesting significant dose changes, *or*

3) clinician suspects that a patient is experiencing a drug-drug interaction involving Methadone, *or*

4) clinician is considering split dosing of methadone for the patient, *or*

5) patient is pregnant, and clinician identifies need to screen for changes in metabolism of methadone.

F. Quantitative testing of a limited number drugs may be performed for the purpose of monitoring therapeutic response when the drug is being used as a mood stabilizer or to control a seizure disorder:

1) Carbamazepine

[15] Elements of the 'Drugs of Abuse10 Panel' vary by provider, but commonly include: marijuana, cocaine, phencyclidine, methamphetamine, methadone, amphetamine (capable of detecting MBDB, MDA, MDEA, MDMA), barbiturates, benzodiazepine, and tricyclic antidepressants.

2) Clozapine
3) Dipropylacetic acid
4) Lithium
5) Phenytoin

II. Exclusions

Specific drug quantitation or confirmation testing are performed for forensic or legal purposes.

Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation

Criteria for Treatment Status Review

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for the treatment review.

I. Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

A. The patient has, or is being evaluated for, a DSM-IV-TR diagnosis on Axis I and/or Axis II.

B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I and/or Axis II.

C. One of the following:

1) the patient has symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I or Axis II disorder. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas consistent with a GAF (DSM-IV-TR Axis V) score of less than 71, *or*

2) the patient has a persistent illness described in DSM-IV-TR with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure, *or*

3) there is clinical evidence that a limited number of additional treatment sessions are required to support termination of therapy, although the patient no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (such as increasing time between appointments, use of community resources, and supporting personal success).

D. The patient does not require a higher level of care.

E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G, H, I, and J must be met to satisfy the criteria for intensity and quality of service. In addition, K must also be met for substance use disorders.

A. There is documentation of a DSM-IV-TR diagnosis on Axis I and/or Axis II, and there are completed assessments on Axes III, IV, and V. The assessment also includes the precipitating event/presenting issues,

specific symptoms and functional impairments, community and natural resources, personal strengths, and the focus of treatment.

B. There is a medically necessary and appropriate treatment plan, or its update, specific to the patient's behavioral, psychological, and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I and/or Axis II. The treatment plan is expected to be effective in reducing the patient's occupational, academic or social functional impairments and:

   1) alleviating the patient's distress and/or dysfunction in a timely manner, *or*

   2) achieving appropriate maintenance goals for a persistent illness, *or*

   3) supporting termination.

C. The treatment plan must identify all of the following:

   1) treatment modality, treatment frequency and estimated duration;

   2) specific interventions that address the patient's presenting symptoms and issues;

   3) coordination of care with other health care services, e.g., PCP or other behavioral health practitioners;

   4) the status of active involvement and/or ongoing contact with patient's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible;

   5) the status of inclusion and coordination, whenever possible, with appropriate community resources;

   6) consideration/referral/utilization of psychopharmological interventions for diagnoses that are known to be responsive to medication;

   7) documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological, and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals and specific measurable end of treatment goals, or specific measurable maintenance treatment goals (if this is maintenance treatment), are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress;

   8) the description of an alternative plan to be implemented if the patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are psychiatric evaluation if not yet obtained, a second opinion, or introduction of adjunctive or different therapies; and

   9) the current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.

D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

E. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.

F. Although the patient has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.

G. Treatment is effective as evidenced by improvement in GAF, SF-BH, CHI, and/or other valid outcome measures.

H. Requested services do not duplicate other provided services.

I. Visits for this treatment modality are recommended to be no greater than one session per week, except for: (i) acute crisis stabilization, or (ii) situations where the treating provider demonstrates more than one visit per week is medically necessary.

J. As the patient exhibits sustained improvement or stabilization of a persistent illness, frequency of visits should be decreased over time (e.g., once every two weeks or once per month) to reinforce and encourage self-efficacy, autonomy, and reliance on community and natural supports.

K. For substance use disorders, treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

Outpatient Applied Behavior Analysis

Parameters for the treatment of individuals with Autism Spectrum Disorders

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient applied behavior analysis (ABA)[16].

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

There must be documentation of:

A. An established DSM-IV-TR diagnosis of a Pervasive Developmental Disorder.[17]

B. Presence of deficits or behaviors that:

- Significantly interfere with home or community activities; *and*
- Presents a health or safety risk to self or others (such as self-injury, aggression toward others, destruction of property, stereotyped/repetitive behaviors, elopement, severe disruptive behavior).

C. Less-intensive behavior treatment or other therapy has been seriously considered or has been applied and has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors.

D. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D, and E must be met to satisfy the criteria for intensity and quality of service.

A. A reasonable expectation on the part of a qualified treating health care professional[18] who has completed an initial evaluation of the patient, that the individual's behavior will improve significantly with ABA therapy provided by, or supervised by, a Magellan credentialed, certified and contracted ABA provider. The diagnosis must be made by a physician trained in screening and diagnosis of autism spectrum disorders (ASD), and a confirmation and treatment plan must be developed by a board certified professional trained in Applied Behavior Analysis or other treatment modalities.

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[16] Applies to Other Related Structured Behavioral Programs for members of AmeriHealth NJ.

[17] The DSM-IV-TR, Fourth Edition, 2000 has established a category of Pervasive Developmental Disorders, which includes: Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, Rett's Disorder, and Pervasive Development Disorder Not Otherwise Specified. However, ABA has not been shown to be effective with Rett's Disorder; therefore, Rett's Disorder is excluded from this criterion.

[18] Qualified treating health care professionals are defined as a pediatrician, a provider independently licensed and credentialed by and contracted with Magellan, or as permitted by applicable state and/or federal law.

B. The treatment plan is built upon individualized goals. The treatment plan must delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors. The treatment plan must include care coordination involving parents or caregiver, school, state disability programs and others as applicable. Treatment plan objectives are measurable, based upon clinical observation, outcome measurement assessment and tailored to the patient.

C. Parent or caregiver training and support is incorporated into the treatment plan and required for generalization of treatment.

D. Interventions emphasize generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors.

E. Interventions are consistent with ABA techniques.

Criteria for Continued Stay

III. Continued Stay

Criteria A or B **and** C, D, E and F must be met to satisfy the criteria for continued stay:

A. Patient continues to meet the criteria defined in above admission criteria.

B. New problems or symptoms that meet admission criteria have appeared.

C. A reasonable expectation exists that the patient will benefit from the continuation of ABA services.

D. The treatment plan including care coordination is updated on a frequent basis.

E. Measurable progress is documented or there is a reasonable expectation, based on the patient's clinical history and recent clinical experience that the current treatment is of such benefit to the patient, that withdrawal of treatment will result in the patient's decompensation or the recurrence of signs or symptoms that necessitated treatment.

F. Treatment is not making the symptoms persistently worse.

Exclusion Criteria

IV. Exclusion Criteria

ABA treatment will not be authorized for any of the following purposes:

A. Speech therapy

B. Occupational therapy

C. Vocational rehabilitation

D. Supportive respite care

E. Recreational therapy

F. Orientation and mobility.

Discharge Criteria

V. Discharge Criteria

Criteria A, B, C or D must be met to satisfy the criteria for discharge.

A. No meaningful, measurable improvement has been documented in the patient's behavior(s) for a period of at least six months of optimal treatment. In addition, the patient has reached their cognitive potential, and there is no reasonable expectation that termination of the current treatment would put the patient at risk for decompensation or the recurrence of signs and symptoms that necessitated treatment.

- For changes to be "meaningful" they must be durable over time beyond the end of the actual treatment session, and generalizable outside of the treatment setting to the patient's residence and to the larger community within which the patient resides.

B. Treatment is making the symptoms persistently worse.

C. The patient has achieved adequate stabilization of the deficits and behaviors and can be managed in a less intensive environment e.g., school setting.

D. The patient demonstrates an inability to maintain long-term gains from the proposed plan of treatment.

Psychological Testing

Criteria for Authorization

Prior to psychological testing, the individual must be assessed by a qualified behavioral health care provider. The diagnostic interview determines the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist with necessary differential diagnosis issues and/or to help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed since the institution of the initial treatment plan and there is no clear explanation for the lack of improvement.

I. **Severity of Need**

Criteria A, B and C must be met:

A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.

B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.

C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment.

II. **Intensity and Quality of Care**

Criteria A and B must be met:

A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), medical psychologist (M.P.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.

B. Requested tests must be valid and reliable in order to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in *Standards for Educational and Psychological Testing.* [CC9]

III. **Exclusion Criteria**

Psychological testing will not be authorized under any of the following conditions:

A. The testing is primarily for educational or vocational purposes.

B. The testing is primarily for the purpose of determining if an individual is a candidate for a specific medication or dosage.

C. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.

D. The testing results could be invalid due to the influence of a substance, substance abuse, substance withdrawal, or any situation that would preclude valid psychological testing results from being obtained (e.g., an individual who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).

E. The testing is primarily for diagnosing attention-deficit hyperactive disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.

F. Two or more tests are requested that measure the same functional domain.

G. Testing is primarily for forensic (legal) purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing, or testing that is requested by an administrative body (e.g., a licensing board, Worker's Compensation, or criminal or civil litigation).

H. Requested tests are experimental, antiquated, or not validated.

I. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.

J. The testing is primarily to determine the extent or type of neurological impairment as potentially related to a plan of remediation or treatment, unless allowed by the individual's benefit plan.

K. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances. CC6

Therapeutic Leave of Absence Documentation

A Therapeutic Leave of Absence (TLOA) is any leave from a facility, which is ordered by a physician, is medically necessary, and is not supervised by staff. A leave for medical reasons (e.g., consultations, evaluations, office visits and treatments) is excluded from this definition.

Documentation Guidelines

To ensure that a TLOA is recognized as meeting the above definition, the medical record must contain the following information:

1) a physician must order each TLOA, identify it as a TLOA, and specify the number of leave hours approved, *and*

2) therapeutic rationale must be included in the ITPs and/or physician progress notes, and/or social worker notes, *and*

3) the nurse, physician, or social worker must document the outcome of the TLOA in the medical record.

Medical Necessity

While these guidelines address the documentation of therapeutic leaves of absence, the medical necessity of each leave of absence continues to be determined by the application of the Psychiatric Hospitalization Criteria.

Outpatient Electroconvulsive Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of "last resort".

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.[DD1]

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient's medical status, the treatment history and the patient's preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s)of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*

3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*

4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. All:

1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *and*

2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course, *and*

3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*

2) medical history and examination focusing on neurological, cardiovascular, and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT; *and*

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*

2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:

1) specific medications to be administered during ECT, *and*

2) choice of electrode placement during ECT, *and*

3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

1) seizure duration, including missed, brief, and/or prolonged seizures, *and*

2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

3) electrocardiographic activity, *and*

4) vital signs, *and*

5) oximetry, *and*

6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

1) cardiovascular effects, *and*

2) prolonged seizures, *and*

3) respiratory effects, including prolonged apnea, *and*

4) headache, muscle soreness, and nausea.

F. There are post-ECT stabilization and recovery services, including:

1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

1) the persistence of problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*

2) the emergence of additional problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Inpatient Electroconvulsive Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of "last resort."

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.[DD1]

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient's medical status, the treatment history and the patient's preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*

1) the patient has a history of good response to ECT during an earlier episode of the illness, *or*

2) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. All:

1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *or*

2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*

2) medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*

2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:

1) specific medications to be administered during ECT, *and*

2) choice of electrode placement during ECT, *and*

3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

1) seizure duration, including missed, brief and/or prolonged seizures, *and*

2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

3) electrocardiographic activity, *and*

4) vital signs, *and*

5) oximetry, *and*

6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

1) cardiovascular effects, *and*

2) prolonged seizures, *and*

3) respiratory effects, including prolonged apnea, *and*

4) headache, muscle soreness and nausea.

F. There are post-ECT stabilization and recovery services, including:

1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

1) the persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*

2) the emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Transcranial Magnetic Stimulation Treatment*

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for transcranial magnetic stimulation (TMS).

I. Severity of Need

Criteria A, B, C, D, E, F, and G must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the adult patient has a DSM-IV-TR Axis I diagnosis of a major depressive disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate TMS treatment.

B. TMS will be used only for adults over the age of 22 who are not pregnant.

C. An evidence-based psychotherapy) for depression was attempted and not effective.

D. One or more of the following:
   1) the patient has demonstrated medication treatment-resistance during the current depressive episode as evidenced by a lack of clinical response to four antidepressant trials (one of the trials must be of adequate dose and duration as defined by the most current edition of the *Physicians' Desk Reference*); *or*
   2) the patient has undergone multiple trials of antidepressants and is unable to tolerate therapeutic dose of the medication; *or*
   3) the patient has a history of good response to TMS during an earlier episode of the treatment-resistant major depressive disorder.

E. The patient is medically stable and the patient's status and/or co-morbid medical conditions are not contraindications for TMS.

F. All of the following:
   1) there is a clinical contraindication for electroconvulsive therapy (ECT)[19] or the patient refuses ECT: *and*
   2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure; *and*
   3) the patient can be reasonably expected to comply with post-procedure recommendations.

G. The patient and/or a legal guardian are/is able to understand the purpose, risks and benefits of TMS, and provide(s) consent.

[19] Studies have demonstrated superior efficacy with ECT in major depression (Eranti, Mogg, Pluck, et al. 2007). ECT should not be delayed in cases where symptoms are life-threatening.

II. Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is appropriately trained to provide TMS, to include:

   1) a psychiatric history, including past response to antidepressant medication(s) and/or TMS and/or ECT, mental status and current functioning; *and*

   2) a medical history and examination when clinically indicated.

B. Treatment interventions are guided by quantitative measures of depression such as the Consumer Health Inventory (CHI). Other measures are used if CHI is not available.[20]

C. The physician utilizing this technique must be a board certified psychiatrist privileged by Magellan and/or payer to perform TMS.

D. An attendant/individual trained in basic life support, the management of complications such as seizures, in addition to training in the application of the TMS apparatus, must be present at all times with the patient while the treatment is applied.

E. Access to emergency equipment, including cardiac defibrillator, and suction is readily available while the patient is receiving TMS.

F. When clinically indicated, the patient is released in the care of a responsible adult who can monitor and provide supportive care as needed.

Criteria for Continued Treatment

III. Continued Treatment

Criteria A, B, C and D must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

   1) the persistence of problems that meet the TMS treatment Severity of Need criteria as outlined in I.; *or*

   2) the emergence of additional problems that meet the TMS treatment Severity of Need criteria as outlined in I; *or*

   3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in an exacerbation of the patient's condition and/or status.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

[20] Beck Depression Inventory (BDI-II), the Hamilton Rating Scale for Depression (HamD or HamD-7) and/or or Patient Health Questionnaire (PHQ-9).

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in progress notes, written and signed by the provider.

D. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

***** *Transcranial Magnetic Stimulation Treatment criteria does not take the place of Medicare Local Coverage Determinations (LCDs).*

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