Medical Necessity Criteria Guidelines - adopted for CHAMPVA

(Civilian Health and Medical Program of the Department of Veteran's Affairs)

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Preamble - Principles of Medical Necessity Determinations

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan[1] 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. 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.

The level of care criteria that follow are guidelines for determining medical necessity for Diagnostic *and Statistical Manual of Mental Disorders Fifth Edition (DSM-5™)* 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 CHAMPVA Health Benefits Plan. Specific information in the CHAMPVA Policy and/or Regulations 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.

Clinical Judgment and Exceptions

The Magellan 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.

[1] In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc. – Employer Services. Other Magellan entities include Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Behavioral Care of Iowa, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of Nebraska, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Behavioral Health Providers of Texas, Inc.; and their respective affiliates and subsidiaries; all of which are affiliates of Magellan Health, Inc. (collectively "Magellan").

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 covered 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.

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.

Magellan Medical Necessity criteria do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

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 four 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

a. 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[2].
b. 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.

2. 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

a. 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.

3. Partial Hospitalization

a. These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least 3 hours/day and are available at least 5 days/week. The services include medical and nursing[3], 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.

4. Outpatient Treatment

a. 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 thirty to sixty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

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.

   c. 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.

   d. 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

4. **Qualified Healthcare Professional:**

An individual that is independently licensed and credentialed by and contracted with Magellan, who performs a service within their scope of practice as permitted by applicable state and/or federal law.

5. Physician:

Doctors of medicine (MD) and doctors of osteopathic medicine (DO) with an unrestricted license to practice medicine.

6. Geriatric

Generally, 65 years of age or older, however treatment must not only address chronological age, but emotional and physical conditions.

7. Adolescent

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.

8. Standardized Screening Tools

Tools used for cognitive assessment include, but are not limited to, the Mini-Mental Status Examination (MMSE) and the Montreal Cognitive Assessment (MoCA).

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, and C and one of , D, E, or F 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-5 codes.

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. Due to the imminent risk or medical instability requiring admission, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is clearly indicated.

D. 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.

E. 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.

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 no more than 24 hours prior to or 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. 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. The 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.

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, 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* 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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation, *or*

3. 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 DSM-5 diagnosis, 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.

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.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Hospitalization, Psychiatric, Child and Adolescent[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, B, and C and one of D, E, or F 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-5 codes.

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. Due to the imminent risk or medical instability requiring admission, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is clearly indicated.

D. 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.

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[4] 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 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.

F. 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 no more than 24 hours prior to or 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. 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. The 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.

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, 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, 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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation ,*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 DSM-5 diagnosis, 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. 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.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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, and C and one of D, E, or F 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-5 codes.

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. Due to the imminent risk or medical instability requiring admission, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is clearly indicated.

D. The ptient 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.

E. 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.

F. 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 no more than 24 hours prior to or 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 required with standardized screening tools for cognitive assessment. 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. . The evolving clinical status is documented by daily progress notes, one of which

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

evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.

C. The care is expected to include availability of activities/resources to meet the social needs of older patients with chronic mental illness. These needs would typically include at a minimum company, daily activities and having a close confidant, such as staff members or visitors.

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, 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, 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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation , *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 DSM-5 diagnosis , 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.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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, Binge Eating Disorder, or Unspecified Feeding or Eating Disorder. 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 in the last 72 hours that may include but is not limited to: clinically signficant disturbances in heart rate, blood pressure, including orthostatic blood pressure changes; hypokalemia, hypophosphatemia, hypomagnesemia, hypo- or hyperglycemia, other electrolyte imbalance, temperature, and hydration; clinically significant compromise in liver, kidney, or cardiovascular function; and/or poorly controlled diabetes related to eating disorder behavior

2) the child or adolescent patient has physiologic instability in the last 72 hours that may include but is not limited to: clinically significant disturbances in heart rate or blood pressure, including orthostatic blood pressure changes; hypokalemia, hypophosphatemia, or hypomagnesemia hypo- or hyperglycemia, other electrolyte imbalance, temperature, and hydration; clinically significant compromise in liver, kidney, or cardiovascular function; and/or poorly controlled diabetes related to eating disorder behavior.

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, , will have physiologic instability as described above. However, if body weight is equal

[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.

to or greater than 75% of IBW), 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 is within 5-10 pounds of 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 to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious 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).

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, C and D 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 substance use disorders and if present, these should be

B. 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.

C. 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. For patients diagnosed with Anorexia Nervosa the treatment plan must include a component for face-to face meal supervision for at least one meal per day during the hospital stay. 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.

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 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 either F or G 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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation *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 DSM-5 diagnosis, 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. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

F. 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.

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

[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.

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.

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, D, and E 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. Treatment interventions are guided during treatment by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

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

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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, G and H must be met to satisfy the criteria for severity of need.

A. The patient has a substance use disorder as defined by DSM-5 diagnosis 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, or

3) there is clinical evidence that the patient is not likely to respond at a less-intensive level of care

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 demonstrates motivation to manage symptoms or make behavioral change , as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

H. The patient is capable of developing skills to manage symptoms or make behavioral change

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 a DSM-5 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. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment. 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. The care is expected to include availability of activities/resources to meet the social needs of older patients with chronic mental illness. These needs would typically include at a minimum company, daily activities and having a close confidant, such as staff members or visitors.

E. 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.

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

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 inpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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.

F. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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, G, and H must be met to satisfy the criteria for severity of need.

A. The patient has a substance use disorder as defined by DSM-5 diagnosis 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, or

3) there is clinical evidence that the patient is not likely to respond at a less-intensive level of care

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 demonstrates motivation to manage symptoms or make behavioral change as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

H. The patient is 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-5 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.

E. 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.

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 inpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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.

F. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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-5 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-5 diagnosis must result from a face-to-face psychiatric evaluation. A psychologist or psychiatrist must recommend treatment and direct the treatment plan.

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) at least once-a-week psychiatric reassessments, if indicated, *and*
2) 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*
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. 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, F, and G 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. Subjective opinions without objective clinical

information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

F. 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.

G. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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 Unspecified Feeding or Eating Disorder, 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, Binge Eating Disorder, Unspecified Feeding or Eating Disorder, or Avoidant/Restrictive Intake Disorder. 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. A patient has anorexia, and has a body weight less than 85% of Ideal Body Weight (IBW) 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 Unspecified Feeding 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, Cand 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 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. A psychologist or psychiatrist must recommend treatment and direct the treatment plan.

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 once-a-week psychiatric reassessments, if indicated, *and*
2) 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*
3) psychotropic medications, if medically indicated, to be used with specific target symptoms identified, *and*
4) evaluation and management for current medical problems, *and*
5) evaluation and treatment for concomitant substance use issues, *and*
6) for patients diagnosed with Anorexia Nervosa the treatment plan must include a component for face-to face meal supervision for at least one meal per day during the hospital stay.
7) 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 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, F, G, and H must be met to satisfy the criteria for continued stay. Additionally, if anorectic, criterion I 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. Subjective opinions without objective clinical information or

evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

I. 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.

Partial Hospitalization, Psychiatric, Adult and Geriatric[8]

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 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-5 diagnosis.

B. A physical examination upon admission, if not done within the past 30 days and/or not available from another provider, must be included in the medical record.

C. Medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session.

D.. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or physician supervision, active treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. 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.

E.. 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.

F. Additionally, either:

[8] Criteria does not take the place of Medicare Local Coverage Determinations (LCDs).

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.

G. 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. 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 prior to admission by a psychiatrist or other authorized health care professional with admitting privileges operating within the scope of their license , frequent nursing and/or physician supervision, active treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician.

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.

E. For patients over 60 years of age, assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment.

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 psychiatric illness to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Partial Hospitalization, Psychiatric, Child and Adolescent[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, C, D, E, and F 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-5 diagnosis.

B. physical examination upon admission, if not done within the past 30 days and/or not available from another provider, must be included in the medical record.

C. Medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session.

D. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or physician supervision, active treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. 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.

E. 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.

F. 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.

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[9] Criteria does not take the place of Medicare Local Coverage Determinations (LCDs).

G. 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 prior to admission by a psychiatrist or other authorized health care professional with admitting privileges operating within the scope of their license and frequent nursing and/or physician supervision, active treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. 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, 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 psychiatric illness to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Partial Hospitalization, Eating Disorders[10]

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. 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, Binge Eating Disorder, Unspecified Feeding or Eating Disorder, or Avoidant/Restrictive Intake Disorder. 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-5 diagnosis.

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 three times 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.

[10] Criteria does not take the place of Medicare Local Coverage Determinations (LCDs).

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, D, E, and F 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. A physical examination upon admission, if not done within the past 30 days and/or not available from another provider, must be included in the medical record.

C. Medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session.

D. The individualized plan of treatment includes a structured program with evaluation prior to admission by a psychiatrist, or other authorized health care professional with admitting privileges operating within the scope of their license, frequent nursing and/or physician supervision, active treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. 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).

E. 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. For patients diagnosed with Anorexia Nervosa the treatment plan must include a component for face-to face meal supervision for at least one meal per day during the partial hospital stay. 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.

F. 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, 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), 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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric[11]

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 provider is able to document that the patient has a history of a substance-related disorder meeting DSM-5 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 of substance use rehabilitation services with frequent nursing and/or physician supervision, active treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. Additionally, the patient requires more intensive multidisciplinary evaluation, rehabilitation 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 demonstrates motivation to manage symptoms or make behavioral change. , as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment..

F. The patient is capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

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

[11] Criteria does not take the place of Medicare Local Coverage Determinations (LCDs).

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. A physical examination upon admission, if not done within the past 30 days and/or not available from another provider, must be included in the medical record.

C. Medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session.

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

E. The individualized plan of substance use rehabilitation 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.

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

G. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.[12]

H. For patients over 60 years of age, assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment.

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*

[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.

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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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.

F. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent[13]

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-5 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 of substance use rehabilitation services with frequent nursing and/or physician supervision, active rehabilitation treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. 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, 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. A physical examination upon admission, if not done within the past 30 days and/or not available from another provider, must be included in the medical record.

[13] Criteria does not take the place of Medicare Local Coverage Determinations (LCDs).

C. Medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session.

D. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist or an Addiction Medicine Physician within 48 hours and frequent nursing and/or physician supervision, active substance use rehabilitation treatment each program day, and assessment no less than 3 times weekly by a professional nurse or a physician, one of which must be by a physician. 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.

E. The individualized plan of substance use rehabilitation 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.

F. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.[14]

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.

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. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

[14] 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.

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.

G. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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, E, and F must be met to satisfy the criteria for severity of need.

A. The patient has, or is being evaluated for, a DSM-5 diagnosis.

B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-5 psychiatric/substance-related disorder(s).

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, academic, or social), that are the direct result of a DSM-5 diagnosis. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas. *or*

2) the patient has a persistent illness described in DSM-5 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 demonstrates motivation to manage symptoms or make behavioral change as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment..
F. The patient is 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, J, and K must be met to satisfy the criteria for intensity and quality of service. In addition, L must also be met for substance use disorders.

A. There is documentation of a DSM-5 diagnosis. 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-5 psychiatric/substance-related disorder(s). 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-5 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; an

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 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 to two sessions 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. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

L. For substance use disorders, treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-

indicated. For substance use disorders, 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.

Psychological Testing[15]

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.

B. Requested tests must be standardized, 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*.

III. Exclusion Criteria

[15] Criteria does not take the place of Medicare Local Coverage Determinations (LCDs).

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.

L. Structured interview tools that do not have psychometric properties or normative comparisons.

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.

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