



Medical Necessity Criteria Guidelines - Yale

Version 1.0

Effective Date: January 1, 2016

Updated: October 12, 2015

Table of Contents

[TOC](#)

Preamble - Principles of Medical Necessity Determinations	iii
Medical Necessity Definition	v
Levels of Care & Service Definitions.....	vi
Term Definitions.....	ix
Hospitalization, Psychiatric, Adult	11
Hospitalization, Psychiatric, Child and Adolescent	14
Hospitalization, Psychiatric, Geriatric.....	18
Hospitalization, Eating Disorders	22
Hospitalization, Substance Use Disorders, Detoxification	26
Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric	28
Hospitalization, Substance Use Disorders, Rehabilitation Treatment, Child and Adolescent	32
Subacute Hospitalization, Psychiatric, Adult.....	36
Subacute Hospitalization, Psychiatric, Geriatric	39
Subacute Hospitalization, Psychiatric, Child and Adolescent	42
23-Hour Observation.....	45
Residential Treatment, Psychiatric, Adult and Geriatric	47
Residential Treatment, Psychiatric, Child and Adolescent.....	50
Residential Treatment, Eating Disorders.....	53
Residential Treatment, Substance Use Disorders, Detoxification.....	57
Residential Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric	59
Residential Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent	62
Partial Hospitalization, Psychiatric, Adult and Geriatric	66
Partial Hospitalization, Psychiatric, Child and Adolescent	69
Partial Hospitalization, Eating Disorders	72
Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric.....	75
Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent.....	78
Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric	81
Intensive Outpatient Treatment, Psychiatric, Child and Adolescent	84
Intensive Outpatient Treatment, Eating Disorders	87
Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric..	90

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent.....	93
Ambulatory, Substance Use Disorders, Detoxification.....	96
Ambulatory, Substance Use Disorders, Buprenorphine Maintenance	98
Ambulatory, Substance Use Disorders, Laboratory Screening of Drugs/Substances of Abuse	101
Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation	103
Psychological Testing	108
Therapeutic Leave of Absence Documentation	110
Outpatient Electroconvulsive Therapy	111
Inpatient Electroconvulsive Therapy.....	115

Preamble - Principles of Medical Necessity Determinations

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan¹ 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 the *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 member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which medical necessity criteria are applicable.

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

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").

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. As in the review of non-exceptional cases, clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases.

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

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

1. Hospitalization

- 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.
- 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. For crisis and 23-hour programs, the psychiatric hospitalization criteria apply for medical necessity reviews. For hospital-level substance abuse rehabilitation, the Hospitalization, Rehabilitation Treatment, Substance Use Disorder criteria set applies. For subacute hospitalization, the Hospitalization, Subacute criteria set applies.

2. Subacute Hospitalization

- a. The subacute hospital level of care is designed to meet the needs of a patient with mental health problems that require an inpatient setting due to potential for harm to self or to others or potential for harm to self due to an inability to adequately care for his/her personal needs without presenting an imminent threat to himself/herself or to others.
- b. The purpose of subacute care programs is to provide rehabilitation and recovery services and to assist in a patient's return to baseline function and transition back into the community. Subacute care programs serve patients who require less-intensive care than traditional acute hospital care, but more intensive care than residential treatment. Twenty-four hour monitoring and

supervision by a multidisciplinary behavioral health treatment team provide a safe and effective treatment environment.

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

3. 23-Hour Observation

- a. The main objective of 23-hour observation is to promptly evaluate and stabilize individuals presenting in a crisis situation. This level of care provides up to 23 hours and 59 minutes of observation and crisis stabilization, as needed. Care occurs in a secure and protected environment staffed with appropriate medical and clinical personnel, including psychiatric supervision and 24-hour nursing coverage.
- b. Aspects of care include a comprehensive assessment and the development and delivery of a treatment plan. The treatment plan should emphasize crisis intervention services intended to stabilize and restore the individual to a level of functioning that does not necessitate hospitalization. In addition, 23-hour observation may be used to complete an evaluation to determine diagnostic clarification to establish the appropriate level of care. As soon as the risk level is determined, diagnostic clarity is established, and/or crisis stabilization has been achieved, appropriate referral and linkage to follow-up services will occur.
- c. If clinical history or initial presentation suggested that the individual required a secure and protected inpatient level of care for more than 23 hours and 59 minutes, this level of care would not be appropriate.

4. Residential Treatment

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

of care are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level of care may vary by state.

5. 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 4 hours/day and are available at least 3 days/week. The services include medical and nursing, 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.

6. Intensive Outpatient Programs

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

7. 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 fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

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 an appropriate DSM-5 diagnosis.
- 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.
- 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, 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 a 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

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 an appropriate DSM-5 diagnosis.
- 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.
- 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 a 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 an appropriate DSM-5 diagnosis.
- 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 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.
- 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 living², 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.

² Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

- 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 a 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 Disorders³

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 significant 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 percent of Ideal Body Weight (IBW) or less, will have physiologic instability as described above. However, if body weight is equal

³ 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 percent 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 percent 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 percent 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 addressed in the treatment plan. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment including but not limited to medication monitoring and administration, nutritional services, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. 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.
- 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 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 a 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 percent of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.
- G. 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, Detoxification⁴

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

⁴ 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 a 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-intensive 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 a 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. 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 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.

Subacute Hospitalization, Psychiatric, Adult

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. 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 a DSM-5 diagnosis. There is a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

- B. Either:

- 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
- 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

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

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

II. Admission - Intensity and Quality of Service

Criteria A, B, C, 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 diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.
- C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
 - 1) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 2) at least three-times-a-week psychiatric reassessments, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) evaluation for current medical problems, *and*
 - 5) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*
 - 6) evaluation for concomitant substance use issues, *and*
 - 7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.
- D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.
- 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.

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 subacute hospital 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 be discharged from this level of care.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.
- E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.
- 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.

Subacute Hospitalization, Psychiatric, Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. 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 an appropriate DSM-5 diagnosis. There is a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.
- B. Either:
 - 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
 - 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.
- C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include, but is not limited to: medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living⁵, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.
- D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

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

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 diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.
- C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
 - 1) at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 2) at least three-times-a-week psychiatric reassessments, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) evaluation for current medical problems, *and*
 - 5) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*
 - 6) evaluation for concomitant substance use issues, *and*
 - 7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his or her regular social environment as soon as possible, unless contraindicated.
- D. 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.

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 subacute hospital 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 be discharged from this level of care.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.
- E. There is evidence of at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate treatment resources after the subacute hospitalization.
- 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.

Subacute Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

A. 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 an appropriate DSM-5 diagnosis. There is a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.

B. Either:

- 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
- 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

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

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

II. Admission - Intensity and Quality of Service

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

- A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.
- C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
 - 1) at least weekly family and/or other support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 2) at least three-times-a-week psychiatric reassessments, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*
 - 5) evaluation for current medical problems, *and*
 - 6) evaluation for concomitant substance use issues, *and*
 - 7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.
- D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, 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 subacute hospital 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 be discharged from this level of care.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the provider.
- E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.
- 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.

23-Hour Observation

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a diagnosed or suspected psychiatric and/or substance use disorder. A psychiatric and/or substance use disorder is defined as a disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-5. There may be a lack of a primary definitive DSM-5 diagnosis and/or an incomplete understanding of the patient's clinical needs due to a lack of clinical information or an evolving clinical condition (e.g., intoxication) in which an extended observation period is medically necessary in order to establish a primary, definitive DSM-5 diagnosis and subsequent treatment plan.

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

- C. Clinical interventions emphasize crisis intervention, relapse prevention and motivational strategies with the intent to stabilize the patient and enhance motivation for change utilizing medication management, individual therapy and/or family or other support system involvement (the frequency of which will be determined by what the treatment team believes is needed to stabilize and re-evaluate the patient) with focus on proximal events in a brief solution-focused model.
- D. Consultation services are available for general medical, pharmacology and psychological services.
- E. Outpatient treatment providers and/or primary care physicians are consulted during the observation period as clinically indicated (and with the patient's documented consent).
- F. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in the admission to a 23-hour observation bed, and this discharge plan begins to identify appropriate treatment resources following discharge. Reasonable attempts are made to coordinate the treatment and affect a timely disposition plan in collaboration with current treatment providers.

Criteria for Continued Stay

III. Continued Stay

- Not Applicable

Criteria for Discharge

IV. Discharge Criteria

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

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

Residential Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. There is clinical evidence that the patient has a DSM-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, 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 diagnosis must result from a face-to-face psychiatric evaluation. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.

- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
- C. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
 - 1) at least once-a-week psychiatric reassessments, if indicated, *and*
 - 2) weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*
 - 5) evaluation for concomitant substance use issues, *and*
 - 6) integrated treatment, rehabilitation and support provided by a multidisciplinary team, *and*
 - 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. 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. 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.
- B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.
- E. There is evidence of weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.
- 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, 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.
- 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.

- B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.
- E. There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.
- 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, or Unspecified Feeding or Eating 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, C, and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family members and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of internal controls to prevent excessive food restricting, bingeing, 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.

Residential Treatment, Substance Use Disorders, Detoxification⁶

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.
- B. Detoxification cannot be safely or effectively managed at a less-intensive level of care and/or by an organized support system.
- C. Detoxification at an acute inpatient level of care is not required because the patient does not present with:
 - 1) co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered, *or*
 - 2) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*
 - 3) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E, 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 licensed registered nurse

⁶ 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. This staffing must provide 24-hour on-site services, including skilled observation and medication administration.

- C. Treatment must include at least once-a-week psychiatric reassessments, if indicated, *and*
- D. Documentation of blood and/or urine drug screen is ordered upon admission.
- E. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.
- F. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.
- G. Treatment progress is assessed at least daily and treatment interventions are guided during treatment by quantitative measures of withdrawal such as the CIWA-Ar or COWS if applicable.

Criteria for Continued Stay

III. Continued Stay

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

- A. Admission criteria continue to be met.
- B. There are physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.
- C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-residential treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.
- 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.

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

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The patient has a substance-related disorder as defined by a 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 a residential treatment program.
- C. The patient exhibits a pattern of moderate or severe substance use and/or addictive disorder as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
- D. There is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable and related to current abuse of substances such as medical and physical instability which would prohibit safe treatment in a less-intensive setting.
- E. One of the following must be met to satisfy criterion E:
 - 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-intensive 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. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care. The patient

does not have significant co-morbid condition(s). 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 diagnosis must result from a face-to-face behavioral health evaluation within the past 48 hours by a psychiatrist or an Addiction Medicine Physician. The patient has been determined to be medically and psychiatrically stable. With the geriatric patient, as part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
- C. Treatment includes at least once-a-week psychiatric reassessments, if indicated.
- D. Additionally, there is sufficient availability of medical and nursing services to manage this patient's ancillary co-morbid medical conditions.
- E. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.
- F. 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.
- G. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and licensed registered nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, 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 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. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular reviews and revisions that include ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.
- C. There is evidence of regular caretakers'/guardians'/family members' involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.
- 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, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The patient has a substance-related disorder as defined by a 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 a residential treatment program.
- C. The patient exhibits a pattern of moderate or severe substance use and/or addictive disorder as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
- D. There is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable and related to current abuse of substances such as medical and physical instability which would prohibit safe treatment in a less-intensive setting.
- E. One of the following must be met to satisfy criterion D:
 - 1. despite recent (i.e., the past 3 months), appropriate, professional intervention, at a less-intensive level of care the patient is continually unable to maintain abstinence and recovery, *or*
 - 2. the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intensive level of care and alternative living situations are not available or clinically appropriate, *or*

there is clinical evidence that the patient is not likely to respond at a less-intensive level of care
- F. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care. The patient does not have significant co-morbid condition(s).

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, and F 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 behavioral health evaluation within the past 48 hours by a psychiatrist or an Addiction Medicine Physician. The patient has been determined to be medically and psychiatrically stable.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
- C. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and licensed registered nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. Treatment must include at least once-a-week psychiatric reassessments, if indicated.
- E. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.
- F. 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 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. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.
- C. The individual plan of active treatment includes regular family and/or support system involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.
- 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, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of an appropriate DSM-5 diagnosis.

B. 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.

C. Either:

- 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
- 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally, either:

- 1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*
- 2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

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

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E, F and G 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 by a psychiatrist within 48 hours, 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.
- E. 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.
- 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.
- G. 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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy.

Presence of the illness(es) must be documented through the assignment of an appropriate DSM-5 diagnosis.

B. 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.

C. Either:

- 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
- 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally, either:

- 1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*
- 2) the patient is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

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

II. Admission - Intensity and Quality of Service

Criteria A, B, C, 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 by a psychiatrist within 48 hours 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.
- E. 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.
- 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), *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

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, or Unspecified Feeding or Eating 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 an 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 bingeing, 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.
- 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 by a psychiatrist within 48 hours, 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 bingeing 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

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.

- 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.⁷
- 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.

⁷ 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.

- 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.
- 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

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.

- 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.

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.

- E. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.⁸

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.
- 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

⁸ 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.

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.

Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment.
- B. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy.
- C. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.
- D. The impairment results in at least one of the following:
 - 1) a clear, current risk to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*
 - 2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*
 - 3) an emerging/impending risk to the safety or property of the patient or of others.
- E. Either:
 - 1) for patients with persistent or recurrent disorders, the patient's past history or current clinical evidence indicates that when the patient has experienced similar clinical circumstances either less-intensive treatment was not or likely would not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others. 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.
 - 2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the

disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others. 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. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services, and is capable of seeking professional support and/or support from caretakers/guardians/family members outside of program hours as needed.
- 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 intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups. The treatment plan actively encourages the coordination of care among the patient's providers.
- D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.
- 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, and C must be met to satisfy the criteria for continued stay.

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

- 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) difficulty and/or lack of coordination of a variety of outpatient services by providers/patient/family supports necessitating use of IOP to ensure this missing component, *or*
 - 4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment. 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 the patient attends the intensive outpatient program, written and signed by the provider.
- C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment.
- B. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy.
- C. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.
- D. The impairment results in at least one of the following:
 - 1) a clear, current risk to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*
 - 2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*
 - 3) an emerging/impending risk to the safety or property of the patient or of others.
- E. Either:
 - 1) for patients with persistent or recurrent disorders, the patient's past history or current clinical evidence indicates that when the patient has experienced similar clinical circumstances either less-intensive treatment was not, or likely would not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others. 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*
 - 2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-

intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others. 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. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.
- 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 intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups. The treatment plan encourages the coordination of care among the patient's providers.
- D. A Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

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

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

- 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) difficulty and/or lack of coordination of a variety of outpatient services by providers/patient/family supports necessitating use of IOP to ensure this missing component, *or*
 - 4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment. 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 the patient attends the intensive outpatient program, written and signed by the provider.
- C. The individual plan of active treatment includes at least weekly family and/or support system involvement in therapy, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Intensive Outpatient Treatment, Eating Disorders

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Unspecified Feeding or Eating Disorder. There is clinical evidence that the patient's condition can be expected to improve through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.
- B. The impairment from the eating disorder results in at least one of the following, which requires a more intensive and structured level of care than outpatient:
 - 1) a clear, current threat to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*
 - 2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*
 - 3) an emerging/impending risk to the safety or property of the patient or of others.
- C. Either of the following:
 - 1) for patients with a persistent or recurrent eating disorder, the past history or current clinical evidence indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing threats to the patient's medical stability. 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*
 - 2) for patients with an acute eating disorder crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration,

stabilize the eating disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient. 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.

- D. The patient requires an integrated program of dietary counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.
- E. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient appears able to seek professional assistance or other support when not in the intensive outpatient setting.
- F. The patient is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.
- G. If the patient has anorexia and there is clinical evidence that without the structure of an intensive outpatient program, there is a clear current threat to the patient's ability to maintain weight >80% of IBW and a consequent threat to the patient's current medical physiologic stability.

II. Admission - Intensity and Quality of Service

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

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of dietary and exercise counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff within a structured program of treatment. One specific treatment goal of this team is helping the patient internalize better control of urges to restrict food, exercise excessively, binge, purge and/or overuse laxatives/diet pills/diuretics. If anorectic, a related goal is further solidifying the stability of weight gain and/or maintenance sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.
- D. Urine Drug Screen (UDS) is considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Criteria for Continued Stay

III. Continued Stay

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

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment. 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 the patient attends the intensive outpatient program, written and signed by the provider.
- C. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis(es) of a substance-related disorder meeting DSM-5 criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.
- B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.
- C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.
- D. The patient is able to seek professional supports and/or support from caretakers/guardians/family members outside of program hours as needed.
- E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.
- F. The patient 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.
- G. 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, and F must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional support and/or support from

caretakers/guardians/family members must be identified and available to the patient outside of program hours.

- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. Additionally, there is the provision of or coordination with medical and/or nursing services sufficient to manage this patient's ancillary co-morbid medical conditions.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.
- D. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.
- E. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.⁹
- F. 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, and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment. Subjective opinions are NOT sufficient to meet severity of need. There must be objective clinical evidence or objective information to justify 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

⁹ 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.

criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- D. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis(es) of substance-related disorder meeting DSM-5 criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.
- B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.
- C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.
- D. The patient is able to seek professional and/or social supports outside of program hours as needed.
- E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.
- F. The patient 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.
- G. 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, and D must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.
- D. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.¹⁰

Criteria for Continued Stay

III. Continued Stay

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

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment. 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 the patient attends the intensive outpatient program, written and signed by the provider.
- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by

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

attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

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

Ambulatory, Substance Use Disorders, Detoxification¹¹

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The patient has a recent history and pattern of continuous use of substances that have withdrawal syndromes and requires medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that they do not require 24-hour access to physician and/or nurse monitoring, nor a history of medically complicated withdrawal in the past.
- B. Presence of mild to moderate withdrawal symptoms which may be safely managed outside a residential or inpatient setting as evidenced by:
 - 1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*
 - 2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*
 - 3) a CIWA-Ar score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*
 - 4) family and/or social support is available to assist the patient during detoxification.
- C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

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

- A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician or qualified health care professional, such as a nurse practitioner or physician assistant.

¹¹ 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.

- B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.
- C. Documentation that blood and/or urine drug screen is ordered upon commencement of treatment.
- D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.
- E. Treatment considers the use of medication-assisted treatment where indicated to address cravings and relapse prevention unless medically contra-indicated.
- F. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

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

- A. Admission criteria continue to be met.
- B. The patient's condition does not require a higher level of care.
- C. Documentation of signs, symptoms and improvement in withdrawal symptoms are noted, and the treatment plan is re-evaluated and modified as medically appropriate.
- D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-detoxification needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.
- 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.

Ambulatory, Substance Use Disorders, Buprenorphine Maintenance

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

Criteria for Admission

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

I. Admission - Severity of Need

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

- A. The patient has a recent history and pattern of continuous use of opioid substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that they do not require 24-hour access to physician and/or nurse monitoring, nor is there a history of medically complicated withdrawal in the past.
- B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:
 - 1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, such as alcohol or sedative-hypnotics dependence, and
 - 2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, and
 - 3) a COWS score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, and
 - 4) family and/or social support is available to assist the patient during detoxification
- C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

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

- A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician who carries the correct Buprenorphine DEA waiver.
- B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.
- C. Documentation that blood and/or urine drug screen is ordered upon commencement of treatment.
- D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs, including encouragement of member to participate in substance use disorder counseling and/or appropriate support resources, such as 12-step type formats and cognitive based formats.
- E. Treatment interventions are guided by quantitative measures of withdrawal such as COWS.

Criteria for Continued Stay

III. Continued Stay

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

- A. Admission criteria continue to be met.
- B. The patient's condition does not require a higher level of care.
- C. Documentation of signs, symptoms and improvement in steadfast opioid sobriety and abstinence with the ongoing assessment and treatment plan addressing, re-evaluating, and modified as medically appropriate to ensure continued sober success.
- D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate. Use of random blood and/or urine drug screen is a component of monitoring for adherence to treatment recommendations.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-maintenance needs. This plan includes attempts to link to outpatient primary care and ongoing behavioral health counseling (addressing appropriate mental health and substance disorder needs) after obtaining patient consent).

- 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.

Ambulatory, Substance Use Disorders, Laboratory Screening of Drugs/Substances of Abuse

Purpose: To establish the types of laboratory assays and testing frequency that is reasonable and medically necessary for the diagnosis and treatment of a substance use disorder.

Criteria for Authorization

I. Severity of Need

Criteria A and B must be met. In addition C, D, E, and/or F must be met.

- A. The patient has a diagnosed or suspected substance use disorder. Presence of the illness(es) must be documented through the assignment of an appropriate DSM-5 diagnosis.
- B. Screening uses a multi-panel qualitative assay screening approach (e.g., 'Drugs of Abuse 10 Panel'¹², corresponding to CPT code 80100, 80101 and 82055 for alcohol).
- C. Screenings occur upon admission to the substance use disorder rehabilitation program and at ten (10) day intervals to monitor program compliance. Testing at more frequent intervals must be accompanied by documentation of reasons of medical/clinical necessity.
- D. Specific drug quantitation can be performed only when there is an acute change in medical status or drug toxicity must be ruled out.
- E. Quantitative testing of serum methadone levels may be performed only under the following circumstances:
 - 1) patient is in stabilization phase and requesting an increase over 80mg of methadone, *or*
 - 2) a patient is in maintenance phase and requesting significant dose changes, *or*

¹² Elements of the 'Drugs of Abuse10 Panel' vary by provider, but commonly include: marijuana, cocaine, phencyclidine, methamphetamine, methadone, amphetamine (capable of detecting MBDB, MDA, MDEA, MDMA), barbiturates, benzodiazepine, and tricyclic antidepressants.

- 3) clinician suspects that a patient is experiencing a drug-drug interaction involving Methadone, *or*
 - 4) clinician is considering split dosing of methadone for the patient, *or*
 - 5) patient is pregnant, and clinician identifies need to screen for changes in metabolism of methadone.
- F. Quantitative testing of a limited number drugs may be performed for the purpose of monitoring therapeutic response when the drug is being used as a mood stabilizer or to control a seizure disorder:
- 1) Carbamazepine
 - 2) Clozapine
 - 3) Dipropylacetic acid
 - 4) Lithium
 - 5) Phenytoin

II. Exclusions

- Specific drug quantitation or confirmation testing are performed for forensic or legal purposes.

Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation

Criteria for Treatment Status Review

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

I. Severity of Need

Criteria A, B, C, D, 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 and M 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 psychopharmacological 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; and
 - 9) the current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
 - E. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.
 - F. Although the patient has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.
 - G. Treatment is effective as evidenced by improvement in 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 contraindicated.

- M. 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

Criteria for Authorization

Prior to psychological testing, the individual must be assessed by a qualified behavioral health care provider. The diagnostic interview determines the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist with necessary differential diagnosis issues and/or to help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed since the institution of the initial treatment plan and there is no clear explanation for the lack of improvement.

I. Severity of Need

Criteria A, B, and C must be met:

- A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.
- B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.
- C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment.

II. Intensity and Quality of Care

Criteria A and B must be met:

- A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), medical psychologist (M.P.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.
- B. Requested tests must be 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

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.

Outpatient Electroconvulsive Therapy

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of “last resort”.

I. Severity of Need

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

- A. The clinical evaluation indicates that the patient has a DSM-5 diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient’s medical status, the treatment history and the patient’s preference regarding treatment should be considered.
- C. One of the following:
 - 1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*
 - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*
 - 3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*
 - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
- D. The patient’s status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. All:

- 1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *and*
- 2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course, *and*
- 3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

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

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

- 1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*
- 2) medical history and examination focusing on neurological, cardiovascular, and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT; *and*

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

- 1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*
- 2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:

- 1) specific medications to be administered during ECT, *and*

- 2) choice of electrode placement during ECT, *and*
 - 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- D. There is continuous physiologic monitoring during ECT treatment, addressing:
- 1) seizure duration, including missed, brief, and/or prolonged seizures, *and*
 - 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*
 - 3) electrocardiographic activity, *and*
 - 4) vital signs, *and*
 - 5) oximetry, *and*
 - 6) other monitoring specific to the needs of the patient.
- E. There is monitoring for and management of adverse effects during the procedure, including:
- 1) cardiovascular effects, *and*
 - 2) prolonged seizures, *and*
 - 3) respiratory effects, including prolonged apnea, *and*
 - 4) headache, muscle soreness, and nausea.
- F. There are post-ECT stabilization and recovery services, including:
- 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*
 - 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.
- G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

Criteria for Continued Treatment

III. Continued Stay

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

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
 - 1) the persistence of problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*
 - 2) the emergence of additional problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*
 - 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status. 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 treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Inpatient Electroconvulsive Therapy

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of “last resort.”

I. Severity of Need

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

- A. The clinical evaluation indicates that the patient has a DSM-5 diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient’s medical status, the treatment history and the patient’s preference regarding treatment should be considered.
- C. One of the following:
 - 1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*
 - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*
 - 3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*
 - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
- D. The patient’s status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.
- E. Either:

- 1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *or*
 - 2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.
- F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

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

- A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:
- 1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*
 - 2) medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.
- B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
- 1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*
 - 2) required modifications in medications or standard anesthetic technique, if any.
- C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:
- 1) specific medications to be administered during ECT, *and*
 - 2) choice of electrode placement during ECT, *and*
 - 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- D. There is continuous physiologic monitoring during ECT treatment, addressing:
- 1) seizure duration, including missed, brief and/or prolonged seizures, *and*

- 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*
 - 3) electrocardiographic activity, *and*
 - 4) vital signs, *and*
 - 5) oximetry, *and*
 - 6) other monitoring specific to the needs of the patient.
- E. There is monitoring for and management of adverse effects during the procedure, including:
- 1) cardiovascular effects, *and*
 - 2) prolonged seizures, *and*
 - 3) respiratory effects, including prolonged apnea, *and*
 - 4) headache, muscle soreness and nausea.
- F. There are post-ECT stabilization and recovery services, including:
- 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*
 - 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment

III. Continued Stay

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

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
- 1) the persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*
 - 2) the emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

- 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status. 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 treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

Bibliography¹³

A. Child & Adolescent Issues, General

1. Akoff, H., Vitiello, B., Riddle, M., Cunningham, C., Greenhill, L., Swanson, J., et al. (2007). Methylphenidate effects on functional outcomes in the Preschoolers with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal of Child and Adolescent Psychopharmacology*, 17(5), 581-592.
2. Asarnow JR, Jaycox LH, Tang L, Duan N, LaBorde AP, Zeledon LR, Anderson M, Murray PJ, Landon C, Rea MM, Wells KB. (2009). Long-term benefits of short-term quality improvement interventions for depressed youths in primary care. *Am J Psychiatry*. 2009 Sep; 166(9): 1002-10
3. Baroni, A.; Lunsford, JR.; Luckenbaugh, DA.; Towbin, KE; Leibenluft, E. (2009). Practitioner Review: The assessment of bipolar disorder in children and adolescents. *Journal of Child Psychology & Psychiatry*; Mar 2009, Vol. 50 Issue 3, p203-215
4. Biering, P., & Jensen, V. H. (2011). The Concept of Patient Satisfaction in Adolescent Psychiatric Care: A Qualitative Study. *Journal of Child & Adolescent Psychiatric Nursing*, 24(1), 3-10
5. Davis LL, Wisniewski SR, Howland RH, Trivedi MH, Husain MM, Fava M, McGrath PJ, Balasubramani GK, Warden D, Rush AJ. (2010). Does comorbid substance use disorder impair recovery from major depression with SSRI treatment? An analysis of the STAR*D level one treatment outcomes. *Drug Alcohol Depend*. 2010 Mar 1; 107(2-3):161-70.
6. Ford, J., Gagnon, K., Connor, D., & Pearson, G. (2011). History of interpersonal violence, abuse, and nonvictimization trauma and severity of psychiatric symptoms among children in outpatient psychiatric treatment. *Journal of Interpersonal Violence*, 26(16), 3316-3337.
7. Furnier, M., & Levy, S. (2006). Recent trends in adolescent substance use, primary care screening, and updates in treatment options. *Current Opinion in Pediatrics*, 18(4), 352-358.
8. Garrison, D., & Daigler, G. (2006). Treatment settings for adolescent psychiatric conditions. *Adolescent Medicine Clinics*, 17(1), 233-250.
9. Geraghty, K., McCann, K., King, R., & Eichmann, K. (2011). Sharing the load: Parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. *International Journal of Mental Health Nursing*, Vol 20(4), 253-262.
10. Ghuman, J., Riddle, M., Vitiello, B., Greenhill, L., Chuang, S., Wigal, S., et al. (2007). Comorbidity moderates response to methylphenidate in the Preschoolers with

¹³ This is a selected bibliography from all the literature reviewed. Older references have been archived.

- Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal of Child and Adolescent Psychopharmacology*, 17(5), 563-580.
11. Gray, K., Upadhyaya, H., Deas, D., & Brady, K. (2006). Advances in diagnosis of adolescent substance abuse. *Adolescent Medicine Clinics*, 17(2), 411-425.
12. Hoagwood, K. (2005). Family-based services in children's mental health: a research review and synthesis. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 46(7), 690-713.
13. Josephson, A. (2007). Practice parameter for the assessment of the family. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(7), 922-937.
14. Lasky, T., Krieger, A., Elixhauser, A., & Vitiello, B. (2011). Children's hospitalizations with a mood disorder diagnosis in general hospitals in the United States 2000-2006. *Child and Adolescent Psychiatry and Mental Health, Vol 5*, Article 27.
15. Martin, S. R. (2013). Partial hospitalization treatment for preschoolers with severe behavior problems: child age and maternal functioning as predictors of outcome. *Child & Adolescent Mental Health*, 18(1), 24-32.
16. Matson JL; Wilkins J; Fodstad JC. (2010). Children with autism spectrum disorders: a comparison of those who regress vs. those who do not. *Developmental Neurorehabilitation [Dev Neurorehabil]* 2010 Oct; Vol. 13 (1), pp. 37-45.
17. McClendon, D. J. (2011). Sensitivity to change of youth treatment outcome measures: a comparison of the CBCL, BASC-2, and Y-OQ. *Journal of Clinical Psychology*, 67(1), 111-125.
18. Memel, B. (2012). A Quality Improvement Project to Decrease the Length of Stay on a Psychiatric Adolescent Partial Hospital Program. *Journal of Child & Adolescent Psychiatric Nursing*, 25(4), 207-218.
19. Mensinger, JL; Diamond, GS; Kaminer, Y; Wintersteen, MB. (2006). Adolescent and Therapist Perception of Barriers to Outpatient Substance Abuse Treatment. *American Journal on Addictions*; Dec 2006 Supplement, Vol. 15, p16-25.
20. Posner, K., Melvin, G., Murray, D., Gugga, S., Fisher, P., Skrobala, A., et al. (2007). Clinical presentation of attention-deficit/hyperactivity disorder in preschool children: the Preschoolers with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal of Child and Adolescent Psychopharmacology*, 17(5), 547-562.
21. Vitiello, B., Abikoff, H., Chuang, S., Kollins, S., McCracken, J., Riddle, M., et al. (2007). Effectiveness of methylphenidate in the 10-month continuation phase of the Preschoolers with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal of Child and Adolescent Psychopharmacology*, 17(5), 593-604.
22. Winters, N., & Pumariga, A. (2007). Practice parameter on child and adolescent mental health care in community systems of care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(2), 284-299.

B. Consultation-Liaison Psychiatry

1. Subramaniam GA; Lewis LL; Stitzer ML; Fishman MJ. (2004). Depressive symptoms in adolescents during residential treatment for substance use disorders. *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions [Am J Addict]* 2004 May-Jun; Vol. 13 (3), pp. 256-67.

C. Crisis Services

1. Ashcraft L; Anthony W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services (Washington, D.C.) [Psychiatr Serv]* 2008 Oct; Vol. 59 (10), pp. 1198-1202.
2. Henggeler, S., Rowland, M., Halliday-Boykins, C., Sheidow, A., Ward, D., Randall, J., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(5), 543-551.
3. Joy, C., Adams, C., & Rice, K. (2006). Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews (Online)*, (4), CD001087.

D. Detoxification, Hospital

1. Carroll, C., Triplett, P., & Mondimore, F. (2009). The Intensive Treatment Unit: A brief inpatient detoxification facility demonstrating good post detoxification treatment entry. *Journal of Substance Abuse Treatment*, 37(2), 111-119.
2. Collins, E., Kleber, H., Whittington, R., & Heitler, N. (2005). Anesthesia-assisted vs. Buprenorphine- or clonidine-assisted heroin detoxification and naltrexone induction: a randomized trial. *JAMA: The Journal of the American Medical Association*, 294(8), 903-913.
3. Hättenschwiler, J., Rüesch, P., & Hell, D. (2000). Effectiveness of inpatient drug detoxification: links between process and outcome variables. *European Addiction Research*, 6(3), 123-131.
4. Kleber, HD. (2007). Pharmacologic treatments for opioid dependence: detoxification and maintenance options. *Dialogues in Clinical Neuroscience [Dialogues Clin Neurosci]* 2007; Vol. 9 (4), pp. 455-70.
5. Madlung-Kratzer, E., Spitzer, B., Brosch, R., Dunkel, D., & Haring, C. (2009). A double-blind, randomized, parallel group study to compare the efficacy, safety and tolerability of slow-release oral morphine versus methadone in opioid-dependent inpatients willing to undergo detoxification. *Addiction (Abingdon, England)*, 104(9), 1549-1557.
6. Saitz, R., Larson, M., Horton, N., Winter, M., & Samet, J. (2004). Linkage with primary medical care in a prospective cohort of adults with addictions in inpatient detoxification: room for improvement. *Health Services Research*, 39(3), 587-606.
7. Stein BD; Kogan JN; Sorbero M. (2009). Substance abuse detoxification and residential treatment among Medicaid-enrolled adults: rates and duration of subsequent treatment. *Drug and Alcohol Dependence [Drug Alcohol Depend]* 2009 Sep 1; Vol. 104 (1-2), pp. 100-6.

8. Sweeney, L., Samet, J., Larson, M., & Saitz, R. (2004). Establishment of a multidisciplinary Health Evaluation and Linkage to Primary care (HELP) clinic in a detoxification unit. *Journal of Addictive Diseases*, 23(2), 33-45.

E. Detoxification, Ambulatory

1. Albright, J., Ciaverelli, R., Essex, A., Tkacz, J., Ruetsch, C. (2010). Psychiatrist Characteristics that Influence Use of Buprenorphine Medication-Assisted Treatment. *Journal of Addiction Medicine*; 21 January 2010. 10.1097
2. Boothby, L., & Doering, P. (2007). Buprenorphine for the treatment of opioid dependence. *American Journal of Health-System Pharmacy: AJHP: Official Journal of The American Society of Health-System Pharmacists*, 64(3), 266-272.
3. Caldiero, RM; Parran, TV Jr; Adelman, CL; Piche, B. (2006) Inpatient initiation of Buprenorphine maintenance vs. detoxification: can retention of opioid-dependent patients in outpatient counseling be improved? *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions [Am J Addict]* 2006 Jan-Feb; Vol. 15 (1), pp. 1-7.
4. Fiellin, D., Kleber, H., Trumble-Hejduk, J., McLellan, A., & Kosten, T. (2004). Consensus statement on office-based treatment of opioid dependence using Buprenorphine. *Journal of Substance Abuse Treatment*, 27(2), 153-159.
5. Gandhi, D., Jaffe, J., McNary, S., Kavanagh, G., Hayes, M., & Currens, M. (2003). Short-term outcomes after brief ambulatory opioid detoxification with Buprenorphine in young heroin users. *Addiction (Abingdon, England)*, 98(4), 453-462.
6. Horspool, MJ; Seivewright, N; Armitage, CJ; Mathers, N. (2008). Post-Treatment Outcomes of Buprenorphine Detoxification in Community Settings: A Systematic Review. *European Addiction Research*; 2008, Vol. 14 Issue 4, p179-185.
7. Kampman, KM; Pettinati, HM; Lynch, KG; Xie, H; Dackis, C; Oslin, DW; Sparkman, T; Sharkoski, T; O'Brien, CP. (2009) Initiating acamprosate within-detoxification versus post-detoxification in the treatment of alcohol dependence. *Addictive Behaviors [Addict Behav]* 2009 Jun-Jul; Vol. 34 (6-7), pp. 581-6.
8. Katz EC; Schwartz RP; King S; Highfield DA; O'Grady KE; Billings T; Gandhi D; Weintraub E; Glovinsky D; Barksdale W; Brown BS. (2009). Brief vs. extended Buprenorphine detoxification in a community treatment program: engagement and short-term outcomes. *The American Journal of Drug and Alcohol Abuse [Am J Drug Alcohol Abuse]* 2009; Vol. 35 (2), pp. 63-7.
9. Kleber, HD. (2007). Pharmacologic treatments for opioid dependence: detoxification and maintenance options. *Dialogues in Clinical Neuroscience [Dialogues Clin Neurosci]* 2007; Vol. 9 (4), pp. 455-70.
10. Krantz, M., & Mehler, P. (2004). Treating opioid dependence. Growing implications for primary care. *Archives of Internal Medicine*, 164(3), 277-288.
11. Marsch, L., Bickel, W., Badger, G., Stothart, M., Quesnel, K., Stanger, C., et al. (2005). Comparison of pharmacological treatments for opioid-dependent adolescents: a randomized controlled trial. *Archives of General Psychiatry*, 62(10), 1157-1164.

12. Soyka, M., & Horak, M. (2004). Outpatient Alcohol Detoxification: Implementation Efficacy and Outcome Effectiveness of a Model Project. *European Addiction Research, 10*(4), 180-187.
13. Woody GE, Poole SA, Subramaniam G, Dugosh K, Bogenschutz M, Abbott P, Patkar A, Publicker M, McCain K, Potter JS, Forman R, Vetter V, McNicholas L, Blaine J, Lynch KG, Fudala P. (2008). Extended vs. short-term buprenorphine-naloxone for treatment of opioid-addicted youth: A randomized trial. *JAMA*. 2008 Nov 5; 300 (17):2003-11.

F. Eating Disorders

1. American Psychiatric Association. (2006). 'Practice Guideline for the Treatment of Patients with Eating Disorders, Third Edition': Erratum. *The American Journal of Psychiatry, 163*(9), 4-54.
2. Ash, J., Piazza, E., & Anderson, J. (1998). Light therapy in the clinical management of an eating-disordered adolescent with winter exacerbation. *The International Journal of Eating Disorders, 23*(1), 93-97.
3. Attia, E., & Walsh, B. (2007). Anorexia nervosa. *The American Journal of Psychiatry, 164*(12), 1805-1810.
4. Becker, A. (2003). Outpatient management of eating disorders in adults. *Current Women's Health Reports, 3*(3), 221-229.
5. Beumont, P., Hay, P., Beumont, D., Birmingham, L., Derham, H., Jordan, A., et al. (2004). Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *The Australian and New Zealand Journal of Psychiatry, 38*(9), 659-670.
6. Bulik, C., Klump, K., Thornton, L., Kaplan, A., Devlin, B., Fichter, M., et al. (2004). Alcohol use disorder comorbidity in eating disorders: a multicenter study. *The Journal of Clinical Psychiatry, 65*(7), 1000-1006.
7. Bulik, C., Sullivan, P., Tozzi, F., Furberg, H., Lichtenstein, P., & Pedersen, N. (2006). Prevalence, heritability, and prospective risk factors for anorexia nervosa. *Archives of General Psychiatry, 63*(3), 305-312.
8. Cachelin, F., Striegel-Moore, R., Elder, K., Pike, K., Wilfley, D., & Fairburn, C. (1999). Natural course of a community sample of women with binge eating disorder. *The International Journal of Eating Disorders, 25*(1), 45-54.
9. Castro, J., Gila, A., Puig, J., Rodriguez, S., & Toro, J. (2004). Predictors of rehospitalization after total weight recovery in adolescents with anorexia nervosa. *The International Journal of Eating Disorders, 36*(1), 22-30.
10. Crow, S. (2006). Fluoxetine treatment of anorexia nervosa: important but disappointing results. *JAMA: The Journal of the American Medical Association, 295*(22), 2659-2660.
11. Dancyger, I., & Fornari, V. (2005). A review of eating disorders and suicide risk in adolescence. *The Scientific World Journal, 5*803-811.

12. Dalle Grave, R., Calugi, S., El Ghoch, M., Conti, M., & Fairburn, C. (2014). Inpatient cognitive behavior therapy for adolescents with anorexia nervosa: immediate and longer-term effects. *Frontiers In Psychiatry*, 5(14), 1-7 .
13. Fairburn, C., Stice, E., Cooper, Z., Doll, H., Norman, P., & O'Connor, M. (2003). Understanding persistence in bulimia nervosa: a 5-year naturalistic study. *Journal of Consulting and Clinical Psychology*, 71(1), 103-109.
14. Federici, A., & Wisniewski, L. (2013). An intensive DBT program for patients with multidiagnostic eating disorder presentations: a case series analysis. *The International Journal Of Eating Disorders*, 46(4), 322-331.
15. Fisher, M. (2003). The course and outcome of eating disorders in adults and in adolescents: a review. *Adolescent Medicine (Philadelphia, Pa.)*, 14(1), 149-158.
16. Franko, D., Keel, P., Dorer, D., Blais, M., Delinsky, S., Eddy, K., et al. (2004). What predicts suicide attempts in women with eating disorders? *Psychological Medicine*, 34(5), 843-853.
17. Guarda, A., Pinto, A., Coughlin, J., Hussain, S., Haug, N., & Heinberg, L. (2007). Perceived coercion and change in perceived need for admission in patients hospitalized for eating disorders. *The American Journal of Psychiatry*, 164(1), 108-114.
18. Geller, J., Drab-Hudson, D., Whisenhunt, B., & Srikameswaran, S. (2004). Readiness to Change Dietary Restriction Predicts Outcomes in the Eating Disorders. *Eating Disorders*, 12(3), 209-224.
19. Girz, L. (2013). Adapting family-based therapy to a day hospital programme for adolescents with eating disorders: preliminary outcomes and trajectories of change. *Journal Of Family Therapy*, 35, 102-120.
20. Godart, N., Perdereau, F., Rein, Z., Berthoz, S., Wallier, J., Jeammet, P., et al. (2007). Comorbidity studies of eating disorders and mood disorders. Critical review of the literature. *Journal of Affective Disorders*, 97(1-3), 37-49.
21. Gowers, S., & Bryant-Waugh, R. (2004). Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 45(1), 63-83.
22. Halmi, K., Agras, W., Crow, S., Mitchell, J., Wilson, G., Bryson, S., et al. (2005). Predictors of treatment acceptance and completion in anorexia nervosa: implications for future study designs. *Archives of General Psychiatry*, 62(7), 776-781.
23. Jordan, P., Redding, C., Troop, N., Treasure, J., & Serpell, L. (2003). Developing a stage of change measure for assessing recovery from anorexia nervosa. *Eating Behaviors*, 3(4), 365-385.
24. Kaye, W., Bulik, C., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *The American Journal of Psychiatry*, 161(12), 2215-2221.
25. Keel, P., Dorer, D., Eddy, K., Franko, D., Charatan, D., & Herzog, D. (2003). Predictors of mortality in eating disorders. *Archives of General Psychiatry*, 60(2), 179-183.

26. Keel, P., Dorer, D., Franko, D., Jackson, S., & Herzog, D. (2005). Post remission predictors of relapse in women with eating disorders. *The American Journal of Psychiatry*, 162(12), 2263-2268.
27. Kells, M., Davidson, K., Hitchko, L., O'Neil, K., Schubert-Bob, P., & McCabe, M. (2013). Examining supervised meals in patients with restrictive eating disorders. *Applied Nursing Research: ANR*, 26(2), 76-79.
28. Le Grange, D., Binford, R., & Loeb, K. (2005). Manualized family-based treatment for anorexia nervosa: a case series. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(1), 41-46.
29. Le Grange, D., Crosby, R., Rathouz, P., & Leventhal, B. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archives of General Psychiatry*, 64(9), 1049-1056.
30. Marcus, M., & Kalarchian, M. (2003). Binge eating in children and adolescents. *The International Journal of Eating Disorders*, 34 Suppl S47-S57.
31. Mascolo, M. S. (2011). Abuse and clinical value of diuretics in eating disorders therapeutic applications. *International Journal of Eating Disorders*, 44(3), 200-202.
32. Mehler, P., Crews, C., & Weiner, K. (2004). Bulimia: medical complications. *Journal of Women's Health (2002)*, 13(6), 668-675.
33. Miller, K., Grinspoon, S., Ciampa, J., Hier, J., Herzog, D., & Klibanski, A. (2005). Medical findings in outpatients with anorexia nervosa. *Archives of Internal Medicine*, 165(5), 561-566.
34. Misra, M., Aggarwal, A., Miller, K., Almazan, C., Worley, M., Soyka, L., et al. (2004). Effects of anorexia nervosa on clinical, hematologic, biochemical, and bone density parameters in community-dwelling adolescent girls. *Pediatrics*, 114(6), 1574-1583.
35. Modan-Moses, D., Yaroslavsky, A., Novikov, I., Segev, S., Toledano, A., Miterany, E., et al. (2003). Stunting of Growth as a Major Feature of Anorexia Nervosa in Male Adolescents. *Pediatrics*, 111(2), 270.
36. Mont, L., Castro, J., Herreros, B., Paré, C., Azqueta, M., Magriña, J., et al. (2003). Reversibility of cardiac abnormalities in adolescents with anorexia nervosa after weight recovery. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(7), 808-813.
37. Myers, T., Swan-Kremeier, L., Wonderlich, S., Lancaster, K., & Mitchell, J. (2004). The use of alternative delivery systems and new technologies in the treatment of patients with eating disorders. *The International Journal of Eating Disorders*, 36(2), 123-143.
38. Olmsted, M., Kaplan, A., & Rockert, W. (2003). Relative Efficacy of a 4-Day versus a 5-Day Day Hospital Program. *International Journal of Eating Disorders*, 34(4), 441-449.
39. Ornstein, R., Golden, N., Jacobson, M., & Shenker, I. (2003). Hypophosphatemia during nutritional rehabilitation in anorexia nervosa: implications for refeeding and monitoring. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 32(1), 83-88.

40. Pike KM, Roberto CA, and Marcus MD. (2007). Evidence Based and Innovative Psychological Treatments in Gabbard's Treatments of Psychiatric Disorders, 4th Edition. Arlington, VA. American Psychiatric Publishing, Inc.
41. Pike, K., Walsh, B., Vitousek, K., Wilson, G., & Bauer, J. (2003). Cognitive behavior therapy in the post hospitalization treatment of anorexia nervosa. *The American Journal of Psychiatry*, 160(11), 2046-2049.
42. Pompili, M., Girardi, P., Tatarelli, G., Ruberto, A., & Tatarelli, R. (2006). Suicide and attempted suicide in eating disorders, obesity and weight-image concern. *Eating Behaviors*, 7(4), 384-394.
43. Pompili, M., Mancinefli, I., Girardi, P., Ruberto, A., & Tatarefli, R. (2004). Suicide in anorexia nervosa: A meta-analysis. *International Journal of Eating Disorders*, 36(1), 99-103.
44. Quadflieg, N., & Fichter, M. (2003). The course and outcome of bulimia nervosa. *European Child & Adolescent Psychiatry*, 12(9).
45. Riva, G., Bacchetta, M., Cesa, G., Conti, S., & Molinari, E. (2003). Six-Month Follow-Up of In-Patient Experiential Cognitive Therapy for Binge Eating Disorders. *Cyber Psychology & Behavior*, 6(3), 251-258.
46. Rosling, A., Sparen, P., Norring, C., & von Knorring, A. (2011). Mortality of eating disorders: a follow-up study of treatment in a specialist unit 1974-2000. *The International Journal of Eating Disorders*, 44(4), 304-310.
47. Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., et al. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *The American Journal of Psychiatry*, 164(4), 591-598.
48. Segal, A., Kinoshita Kusunoki, D., & Larino, M. (2004). Post-surgical refusal to eat: anorexia nervosa, bulimia nervosa or a new eating disorder? A case series. *Obesity Surgery*, 14(3), 353-360.
49. Signorini, A., De Filippo, E., Panico, S., De Caprio, C., Pasanisi, F., & Contaldo, F. (2007). Long-term mortality in anorexia nervosa: a report after an 8-year follow-up and a review of the most recent literature. *European Journal of Clinical Nutrition*, 61(1), 119-122.
50. Solano, R., Fernández-Aranda, F., Aitken, A., López, C., & Vallejo, J. (2005). Self-injurious behavior in people with eating disorders. *European Eating Disorders Review*, 13(1), 3-10.
51. Soler, J., Soriano, J., Ferraz, L., Grasa, E., Carmona, C., Portella, M., & ... Pérez, V. (2013). Direct experience and the course of eating disorders in patients on partial hospitalization: a pilot study. *European Eating Disorders Review: The Journal Of The Eating Disorders Association*, 21(5), 399-404.
52. Spindler, A., & Milos, G. (2004). Psychiatric comorbidity and inpatient treatment history in bulimic subjects. *General Hospital Psychiatry*, 26(1), 18-23.
53. Stewart, T., & Williamson, D. (2004). Multidisciplinary treatment of eating disorders--Part 1: Structure and costs of treatment. *Behavior Modification*, 28(6), 812-830.

54. Storch, M., Keller, F., Weber, J., Spindler, A., & Milos, G. (2011). Psychoeducation in affect regulation for patients with eating disorders: a randomized controlled feasibility study. *American Journal of Psychotherapy*, 65(1), 81-93.
55. Strober, M. (2004). Managing the chronic, treatment-resistant patient with anorexia nervosa. *International Journal of Eating Disorders*, 36(3), 245-255.
56. Takii, M., Uchigata, Y., Komaki, G., Nozaki, T., Kawai, H., Iwamoto, Y., et al. (2003). An integrated inpatient therapy for type 1 diabetic females with bulimia nervosa: a 3-year follow-up study. *Journal of Psychosomatic Research*, 55(4), 349-356.
57. Walsh, B., Kaplan, A., Attia, E., Olmsted, M., Parides, M., Carter, J., et al. (2006). Fluoxetine after weight restoration in anorexia nervosa: a randomized controlled trial. *JAMA: The Journal of The American Medical Association*, 295(22), 2605-2612.
58. Watson, T., & Andersen, A. (2003). A critical examination of the amenorrhea and weight criteria for diagnosing anorexia nervosa. *Acta Psychiatrica Scandinavica*, 108(3), 175-182.
59. Wildman, P., Lilenfeld, L., & Marcus, M. (2004). Axis I comorbidity onset and parasuicide in women with eating disorders. *International Journal of Eating Disorders*, 35(2), 190-197.
60. Wolfe, B., & Gimby, L. (2003). Caring for the hospitalized patient with an eating disorder. *The Nursing Clinics of North America*, 38(1), 75-99.
61. Wolk, S., Loeb, K., & Walsh, B. (2005). Assessment of patients with anorexia nervosa: Interview versus self-report. *International Journal of Eating Disorders*, 37(2), 92-99.

G. Geriatric Issues

1. Anderson, D., Nortcliffe, M., Dechenne, S., & Wilson, K. (2011). The rising demand for consultation-liaison psychiatry for older people: comparisons within Liverpool and the literature across time. *International Journal of Geriatric Psychiatry*, 26(12), 1231-1235.
2. Borja, B; Borja, CS; Gade, S. (2007). Psychiatric emergencies in the geriatric population. *Clinics in Geriatric Medicine [Clin Geriatr Med]* 2007 May; Vol. 23 (2), pp. 391-400, vii.
3. Busse EW, Blazer DG. (2004). Mood Disorders: Depression and Medical Illness, in Textbook of Geriatric Psychiatry 3rd Edition. Arlington, VA. American Psychiatric Press.
4. Choi S, Rozario P, Morrow-Howell N, Proctor E. (2009). Elders with first psychiatric hospitalization for depression. *Int J Geriatr Psychiatry*. 2009 Jan; 24(1):33-40.
5. Copeland, L., Ettinger, A., Zeber, J., Gonzalez, J., & Pugh, M. (2011). Psychiatric and medical admissions observed among elderly patients with new-onset epilepsy. *BMC Health Services Research*, 1184.
6. Dolder, C., & McKinsey, J. (2011). Antipsychotic polypharmacy among patients admitted to a geriatric psychiatry unit. *Journal of Psychiatric Practice*, 17(5), 368-374.

7. Ellison, J., Kyomen, H., & Harper, D. (2012). Depression in later life: an overview with treatment recommendations. *The Psychiatric Clinics of North America*, 35(1), 203-229.
8. Fischer, C., Cohen, C., Stephens, A., Ross, S., Hoch, J., Cooper, J., & ... Wasylenki, D. (2011). Determining the impact of establishing a psychogeriatric outreach team network in long-term care. *Psychiatric Services (Washington, D.C.)*, 62(3), 299-302.
9. Futeran, S., & Draper, B. M. (2012). An examination of the needs of older patients with chronic mental illness in public mental health services. *Aging & Mental Health*, 16(3), 327-334.
10. Lee MJ, Proctor E, Morrow-Howell N. (2006). Depression outcomes and quality of post-discharge care of elders hospitalized for major depression. *Psychiatr Serv.* 2006 Oct; 57(10):1446-51.
11. Molinari, V., Chiriboga, D., Branch, L., Schinka, J., Schonfeld, L., Kos, L., & ... Hyer, K. (2011). Reasons for psychiatric medication prescription for new nursing home residents. *Aging & Mental Health*, 15(7), 904-912.
12. Paton, J., Fahy, M., & Livingston, G. (2004). Delayed discharge--a solvable problem? The place of intermediate care in mental health care of older people. *Aging & Mental Health*, 8(1), 34-39.
13. Saavedra, J., Cubero, M., & Crawford, P. (2012). Everyday Life, Culture, and Recovery: Carer Experiences in Care Homes for Individuals with Severe Mental Illness. *Culture, Medicine & Psychiatry*, 36(3), 422-441.
14. Samus, Q., Onyike, C., Johnston, D., Mayer, L., McNabney, M., Baker, A., & ... Rosenblatt, A. (2013). 12-month incidence, prevalence, persistence, and treatment of mental disorders among individuals recently admitted to assisted living facilities in Maryland. *International Psychogeriatrics / IPA*, 25(5), 721-731.
15. Sanders, J., Bremmer, M., Comijs, H., Deeg, D., Lampe, I., & Beekman, A. (2011). Cognitive functioning and the natural course of depressive symptoms in late life. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, 19(7), 664-672.
16. Seitz, D. P., Vigod, S. N., Lin, E., Gruneir, A., Newman, A., Anderson, G., & ... Herrmann, N. (2012). Characteristics of Older Adults Hospitalized in Acute Psychiatric Units in Ontario: A Population-Based Study. *Canadian Journal of Psychiatry*, 57(9), 554-563.
17. Steffens, DC. (2008). Separating mood disturbance from mild cognitive impairment in geriatric depression. *International Review of Psychiatry (Abingdon, England) [Int Rev Psychiatry]* 2008 Aug; Vol. 20 (4), pp. 374-81.
18. Steffens, DC; Potter, GG. (2007). Geriatric depression and cognitive impairment. *Psychological Medicine [Psychol Med]* 2008 Feb; Vol. 38 (2), pp. 163-75. *Date of Electronic Publication*: 2007 Jun 22.

H. Hospitalization, Psychiatric, Adult

1. Bartak, A., Andrea, H., Spreeuwenberg, M., Ziegler, U., Dekker, J., Rossum, B., & ... Emmelkamp, P. (2011). Effectiveness of outpatient, day hospital, and inpatient psychotherapeutic treatment for patients with cluster B personality disorders. *Psychotherapy and Psychosomatics*, 80(1), 28-38.
2. Bjornaas, M., Hovda, K., Heyerdahl, F., Skog, K., Drottning, P., Opdahl, A., & ... Ekeberg, O. (2010). Suicidal intention, psychosocial factors and referral to further treatment: a one-year cross-sectional study of self-poisoning. *BMC Psychiatry*, 1058. Retrieved from EBSCOhost.
3. Bloom, J., Williams, M., Land, C., McFarland, B., & Reichlin, S. (1998). Changes in public psychiatric hospitalization in Oregon over the past two decades. *Psychiatric Services* (Washington, D.C.), 49(3), 366-369.
4. Browne, G., Courtney, M., & Meehan, T. (2004). Type of housing predicts rate of readmission to hospital but not length of stay in people with schizophrenia on the Gold Coast in Queensland. *Australian Health Review: A Publication of the Australian Hospital Association*, 27(1), 65-72.
5. Bruffaerts, R., Sabbe, M., & Demyttenaere, K. (2004). Effects of patient and health-system characteristics on community tenure of discharged psychiatric inpatients. *Psychiatric Services* (Washington, D.C.), 55(6), 685-690.
6. Buchanan, J., Dixon, D., & Thyer, B. (1997). A preliminary evaluation of treatment outcomes at a veterans' hospital's inpatient psychiatry unit. *Journal of Clinical Psychology*, 53(8), 853-858.
7. Burgess, A., Douglas, J., Burgess, A., Baker, T., Sauve, H., & Gariti, K. (1997). Hospital communication threats and intervention. *Journal of Psychosocial Nursing and Mental Health Services*, 35(8), 9-16.
8. Capp, H., Thyer, B., & Bordnick, P. (1997). Evaluating improvement over the course of adult psychiatric hospitalization. *Social Work in Health Care*, 25(4), 55-66.
9. Cascardi, M., Poythress, N., & Ritterband, L. (1997). Stability of psychiatric patients' perceptions of their admission experience. *Journal of Clinical Psychology*, 53(8), 833-839.
10. Chiesa, M., Sharp, R., & Fonagy, P. (2011). Clinical associations of deliberate self-injury and its impact on the outcome of community-based and long-term inpatient treatment for personality disorder. *Psychotherapy and Psychosomatics*, 80(2), 100-109.
11. Claassen, C., Hughes, C., Gilfillan, S., McIntire, D., Roose, A., Lumpkin, M., et al. (2000). Toward a redefinition of psychiatric emergency. *Health Services Research*, 35(3), 735-754.
12. Cohen, N., Gantt, A., & Sainz, A. (1997). Influences on fit between psychiatric patients' psychosocial needs and their hospital discharge plan. *Psychiatric Services* (Washington, D.C.), 48(4), 518-523.

13. Davidson, L., Tebes, J., Rakfeldt, J., & Sledge, W. (1996). Differences in social environment between inpatient and day hospital-crisis respite settings. *Psychiatric Services (Washington, D.C.)*, 47(7), 714-720.
14. Dew, R., & McCall, W. (2004). Efficiency of outpatient ECT. *The Journal of ECT*, 20(1), 24-25.
15. Engleman, N., Jobes, D., Berman, A., & Langbein, L. (1998). Clinicians' decision making about involuntary commitment. *Psychiatric Services (Washington, D.C.)*, 49(7), 941-945.
16. Evenson, R., Holland, R., & Cho, D. (1994). A psychiatric hospital 100 years ago: I. A comparative study of treatment outcomes then and now. *Hospital & Community Psychiatry*, 45(10), 1021-1025.
17. Figueroa, R., Harman, J., & Engberg, J. (2004). Use of claims data to examine the impact of length of inpatient psychiatric stay on readmission rate. *Psychiatric Services (Washington, D.C.)*, 55(5), 560-565.
18. Halvorsen, M., Wang, C. E., Eisemann, M., & Waterloo, K. (2010). Dysfunctional Attitudes and Early Maladaptive Schemas as Predictors of Depression: A 9-Year Follow-Up Study. *Cognitive Therapy & Research*, 34(4), 368-379.
doi:10.1007/s10608-009-9259-5
19. Harman, J., Cuffel, B., & Kelleher, K. (2004). Profiling hospitals for length of stay for treatment of psychiatric disorders. *The Journal of Behavioral Health Services & Research*, 31(1), 66-74.
20. Katz S. Hospitalization and the mental health service system. In H Kaplan and B Saddock (Eds.). (2009). *Comprehensive Textbook of Psychiatry* (9th ed). Baltimore, MD: Lippincott, Williams and Wilkins.
21. Krch-Cole, E., Lynch, P., & Ailey, S. (2012). Clients with intellectual disabilities on psychiatric units: care coordination for positive outcomes. *Journal of Psychiatric and Mental Health Nursing*, 19(3), 248-256.
22. Larivière, N. (2011). Multifaceted impact evaluation of a day hospital compared to hospitalization on symptoms, social participation, service satisfaction and costs associated to service use. *International Journal Of Psychiatry In Clinical Practice*, 15(3), 228-240.
23. McFarland, B., & Collins, J. (2011). Medicaid cutbacks and state psychiatric hospitalization of patients with schizophrenia. *Psychiatric Services (Washington, D.C.)*, 62(8), 871-877.
24. Olfson, M., Ascher-Svanum, H., Faries, D., & Marcus, S. (2011). #1 Predicting psychiatric hospital admission among adults with schizophrenia. *Psychiatric Services (Washington, D.C.)*, 62(10), 1138-1145.
25. Pedersen, C. (2013). Processes of In-Hospital Psychiatric Care and Subsequent Criminal Behaviour Among Patients With Schizophrenia: A National Population-Based, Follow-Up Study. *Canadian Journal Of Psychiatry*, 58(9), 515-521.

26. Pfeiffer, P., Ganoczy, D., Bowersox, N., McCarthy, J., Blow, F., & Valenstein, M. (2011). Depression care following psychiatric hospitalization in the Veterans Health Administration. *The American Journal Of Managed Care*, 17(9), e358-e364.
27. Pfeiffer, S., O'Malley, D., & Shott, S. (1996). Factors associated with the outcome of adults treated in psychiatric hospitals: a synthesis of findings. *Psychiatric Services (Washington, D.C.)*, 47(3), 263-269.
28. Pompili, M., Innamorati, M., Serafini, G., Forte, A., Cittadini, A., Mancinelli, I., & ... Tatarelli, R. (2011). Suicide attempters in the emergency department before hospitalization in a psychiatric ward. *Perspectives In Psychiatric Care*, 47(1), 23-34.
29. Prince, J. (2013). Call for Research: Detecting Early Vulnerability for Psychiatric Hospitalization. *Journal Of Behavioral Health Services & Research*, 40(1), 46-56.
30. Prince JD, Akincigil A, Hoover DR, Walkup JT, Bilder S, Crystal S. (2009). Substance abuse and hospitalization for mood disorder among Medicaid beneficiaries. *The American Journal of Public Health*, 99(1), 160-167.
31. Reynolds, W., Lauder, W., Sharkey, S., Maciver, S., Veitch, T., & Cameron, D. (2004). The effects of a transitional discharge model for psychiatric patients. *Journal of Psychiatric and Mental Health Nursing*, 11(1), 82-88.
32. Schmutte, T., Dunn, C., & Sledge, W. (2010). Predicting time to readmission in patients with recent histories of recurrent psychiatric hospitalization: a matched-control survival analysis. *The Journal of Nervous and Mental Disease*, 198(12), 860-863. Retrieved from EBSCOhost.
33. Tecic, T., Schneider, A., Althaus, A., Schmidt, Y., Bierbaum, C., Lefering, R., & ... Neugebauer, E. (2011). Early short-term inpatient psychotherapeutic treatment versus continued outpatient psychotherapy on psychosocial outcome: a randomized controlled trial in trauma patients. *The Journal of Trauma*, 70(2), 433-441.
34. Varner, R., Chen, Y., Swann, A., & Moeller, F. (2000). The Brief Psychiatric Rating Scale as an acute inpatient outcome measurement tool: a pilot study. *The Journal of Clinical Psychiatry*, 61(6), 418-421.
35. Yeaman, C., Gambach, J., Bach, B., Manker, J., Diwan, S., & Corrigan, P. (2003). What happens to people receiving inpatient psychiatric services in mixed rural and urban communities? *Administration and Policy in Mental Health*, 30(3), 247-253.

I. Hospitalization, Psychiatric, Child & Adolescent

1. Becker, D., & Grilo, C. (2007). Prediction of suicidality and violence in hospitalized adolescents: comparisons by sex. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 52(9), 572-580.
2. Biering, P., & Jensen, V. H. (2011). The Concept of Patient Satisfaction in Adolescent Psychiatric Care: A Qualitative Study. *Journal of Child & Adolescent Psychiatric Nursing*, 24(1), 3-10.
3. Case, B., Olfson, M., Marcus, S., & Siegel, C. (2007). Trends in the inpatient mental health treatment of children and adolescents in US community hospitals between 1990 and 2000. *Archives of General Psychiatry*, 64(1), 89-96.

4. Cropsey, K., Weaver, M., & Dupre, M. (2008). Predictors of involvement in the juvenile justice system among psychiatric hospitalized adolescents. *Addictive Behaviors*, 33(7), 942-948.
5. Daniel, S., Goldston, D., Harris, A., Kelley, A., & Palmes, G. (2004). Review of literature on aftercare services among children and adolescents. *Psychiatric Services (Washington, D.C.)*, 55(8), 901-912.
6. Flanders, S., Findling, R., Youngstrom, E., Pandina, G., Rupnow, M., Jensik, S., et al. (2007). Observed clinical and health services outcomes in pediatric inpatients treated with atypical antipsychotics: 1999-2003. *Journal of Child and Adolescent Psychopharmacology*, 17(3), 312-327.
7. McClendon, D. J. (2011). Sensitivity to change of youth treatment outcome measures: a comparison of the CBCL, BASC-2, and Y-OQ. *Journal of Clinical Psychology*, 67(1), 111-125.
8. Meagher, S. (2013). Changing Trends in Inpatient Care for Psychiatrically Hospitalized Youth: 1991-2008. *Psychiatric Quarterly*, 84(2), 159-168. PDF may be purchased
9. Moses, T. (2011). Adolescents' Perspectives About Brief Psychiatric Hospitalization: What is Helpful and What is Not? *Psychiatric Quarterly*, 82(2), 121-137.
10. Patel, N., Hariparsad, M., Matias-Akthar, M., Sorter, M., Barzman, D., Morrison, J., et al. (2007). Body mass indexes and lipid profiles in hospitalized children and adolescents exposed to atypical antipsychotics. *Journal of Child and Adolescent Psychopharmacology*, 17(3), 303-311.
11. Santiago, L., Tunik, M., Foltin, G., & Mojica, M. (2006). Children requiring psychiatric consultation in the pediatric emergency department: epidemiology, resource utilization, and complications. *Pediatric Emergency Care*, 22(2), 85-89.
12. Stellwagen, K., Kerig, P. (2010). Relation of callous-unemotional traits to length of stay among youth hospitalized at a state psychiatric inpatient facility. *Child Psychiatry & Human Development*; Jun 2010, Vol. 41 Issue 3, p251-261.
13. Swadi, H., & Bobier, C. (2005). Hospital admission in adolescents with acute psychiatric disorder: how long should it be? *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 13(2), 165-168.
14. Warner, L., Fontanella, C., & Pottick, K. (2007). Initiation and change of psychotropic medication regimens among adolescents in inpatient care. *Journal of Child and Adolescent Psychopharmacology*, 17(5), 701-712.

J. Hospitalization, Substance-Induced Disorders

1. Alford, D., Compton, P., & Samet, J. (2006). Acute pain management for patients receiving maintenance methadone or Buprenorphine therapy. *Annals of Internal Medicine*, 144(2), 127-134.
2. Dijkgraaf, M., van der Zanden, B., de Borgie, C., Blanken, P., van Ree, J., & van den Brink, W. (2005). Cost utility analysis of co-prescribed heroin compared with

methadone maintenance treatment in heroin addicts in two randomized trials. *BMJ (Clinical Research Ed.)*, 330(7503), 1297.

3. Donaher, P., & Welsh, C. (2006). Managing opioid addiction with Buprenorphine. *American Family Physician*, 73(9), 1573-1578.
4. Fløvig, J., Vaaler, A., & Morken, G. (2009). Substance use at admission to an acute psychiatric department. *Nordic Journal of Psychiatry*, 63(2), 113-119.
5. Kakko, J., Grönbladh, L., Svanborg, K., von Wachenfeldt, J., Rück, C., Rawlings, B., et al. (2007). A stepped care strategy using Buprenorphine and methadone versus conventional methadone maintenance in heroin dependence: a randomized controlled trial. *The American Journal of Psychiatry*, 164(5), 797-803.
6. Kaskutas, L., Witbrodt, J., & French, M. (2004). Outcomes and costs of day hospital treatment and nonmedical day treatment for chemical dependency. *Journal of Studies on Alcohol*, 65(3), 371-382.
7. Mojtabai, R., & Zivin, J. (2003). Effectiveness and cost-effectiveness of four treatment modalities for substance disorders: a propensity score analysis. *Health Services Research*, 38(1 Pt 1), 233-259.
8. Montoya, I., Gorelick, D., Preston, K., Schroeder, J., Umbricht, A., Cheskin, L., et al. (2004). Randomized trial of Buprenorphine for treatment of concurrent opiate and cocaine dependence. *Clinical Pharmacology and Therapeutics*, 75(1), 34-48.
9. Schaefer, J., Cronkite, R., & Hu, K. (2011). Differential relationships between continuity of care practices, engagement in continuing care, and abstinence among subgroups of patients with substance use and psychiatric disorders. *Journal of Studies on Alcohol and Drugs*, 72(4), 611-621.
10. Schwartz, R., Highfield, D., Jaffe, J., Brady, J., Butler, C., Rouse, C., et al. (2006). A randomized controlled trial of interim methadone maintenance. *Archives of General Psychiatry*, 63(1), 102-109.
11. Vocci, F., Acri, J., & Elkashef, A. (2005). Medication development for addictive disorders: the state of the science. *The American Journal of Psychiatry*, 162(8), 1432-1440.
12. Zweben, J., Cohen, J., Christian, D., Galloway, G., Salinardi, M., Parent, D., et al. (2004). Psychiatric symptoms in methamphetamine users. *The American Journal on Addictions / American Academy of Psychiatrists* In *Alcoholism and Addictions*, 13(2), 181-190.

K. Intensive Outpatient, Psychiatric

1. McQuillan, A., Nicastro, R., Guenot, F., Girard, M., Lissner, C., & Ferrero, F. (2005). Intensive dialectical behavior therapy for outpatients with borderline personality disorder who are in crisis. *Psychiatric Services (Washington, D.C.)*, 56(2), 193-197.
2. Wise EA. (2003). Empirical validation of a mental health intensive outpatient program in a private practice setting. *The American Journal of Orthopsychiatry [Am J Orthopsychiatry]* 2003 Oct; Vol. 73 (4), pp. 405-10.

L. Intensive Outpatient, Substance-Related Disorder

1. Fiellin, D., Kleber, H., Trumble-Hejduk, J., McLellan, A., & Kosten, T. (2004). Consensus statement on office-based treatment of opioid dependence using Buprenorphine. *Journal of Substance Abuse Treatment*, 27(2), 153-159.
2. Fiellin, D., Pantalon, M., Chawarski, M., Moore, B., Sullivan, L., O'Connor, P., et al. (2006). Counseling plus Buprenorphine-Naloxone maintenance therapy for opioid dependence. *The New England Journal of Medicine*, 355(4), 365-374.
3. Fudala, P., Bridge, T., Herbert, S., Williford, W., Chiang, C., Jones, K., et al. (2003). Office-based treatment of opiate addiction with a sublingual-tablet formulation of Buprenorphine and Naloxone. *The New England Journal of Medicine*, 349(10), 949-958.
4. Manlandro, J. (2007). Using Buprenorphine for outpatient opioid detoxification. *The Journal of the American Osteopathic Association*, 107(9 Suppl 5), ES11-ES16.
5. Robinson, S. (2006). Buprenorphine-containing treatments: place in the management of opioid addiction. *CNS Drugs*, 20(9), 697-712.
6. Schaefer, J., Cronkite, R., & Hu, K. (2011). Differential relationships between continuity of care practices, engagement in continuing care, and abstinence among subgroups of patients with substance use and psychiatric disorders. *Journal of Studies on Alcohol and Drugs*, 72(4), 611-621.
7. Schottenfeld, R., Chawarski, M., Pakes, J., Pantalon, M., Carroll, K., & Kosten, T. (2005). Methadone versus Buprenorphine with contingency management or performance feedback for cocaine and opioid dependence. *The American Journal of Psychiatry*, 162(2), 340-349.

M. Medical Necessity and Medical Necessity Criteria

1. American Association of Community Psychiatrists: Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version. March 20, 2009.
2. Rosenbaum S, Kamoie B, Mauery DR, Walitt B. (2003) *Medical necessity in private health plans: Implications for behavioral health care*. DHHS Pub No (SMA) 03-3790. 2003 SAMHSA Rockville, MD.

N. Miscellaneous

1. Hales RE, Yudofsky SC, Talbott JA. Textbook of Psychiatry, fifth edition, American Psychiatric Press, Eating Disorders (2008).
2. Jong-Hoon, K., & Hee-Jung, B. (2010). The Relationship between Akathisia and Subjective Tolerability in Patients With Schizophrenia. *International Journal of Neuroscience*, 120(7), 507-511. doi:10.3109/00207451003760106.

O. Partial Hospitalization, Psychiatric, Child/Adolescent and Adult

1. Bartak, A., Andrea, H., Spreeuwenberg, M., Ziegler, U., Dekker, J., Rossum, B., & ... Emmelkamp, P. (2011). Effectiveness of outpatient, day hospital, and inpatient psychotherapeutic treatment for patients with cluster B personality disorders. *Psychotherapy and Psychosomatics*, 80(1), 28-38.

2. Biering, P., & Jensen, V. H. (2011). The Concept of Patient Satisfaction in Adolescent Psychiatric Care: A Qualitative Study. *Journal of Child & Adolescent Psychiatric Nursing*, 24(1), 3-10.
3. Kallert, T., Priebe, S., McCabe, R., Kiejna, A., Rymaszewska, J., Nawka, P., et al. (2007). Are day hospitals effective for acutely ill psychiatric patients? A European multicenter randomized controlled trial. *The Journal of Clinical Psychiatry*, 68(2), 278-287.
4. Kiser LJ, Heston JD, Pruitt DB. Partial Hospitalization and Ambulatory Behavioral Health Services. In H Kaplan and B Saddock (Eds.). (2009). *Comprehensive Textbook of Psychiatry* (9th ed). Baltimore, MD: Lippincott, Williams and Wilkins
5. Marshall, M., Crowther, R., Almaraz-Serrano, A., Creed, F., Sledge, W., Kluiter, H., et al. (2003). Day hospital versus admission for acute psychiatric disorders. *Cochrane Database of Systematic Reviews (Online)*, (1), CD004026.
6. Mackenzie, C., Rosenberg, M., & Major, M. (2006). Evaluation of a psychiatric day hospital program for elderly patients with mood disorders. *International Psychogeriatrics / IPA*, 18(4), 631-641.
7. Mazza, M., Barbarino, E., Capitani, S., Sarchiapone, M., & De Risio, S. (2004). Day hospital treatment for mood disorders. *Psychiatric Services (Washington, D.C.)*, 55(4), 436-438.
8. McClendon, D. J. (2011). Sensitivity to change of youth treatment outcome measures: a comparison of the CBCL, BASC-2, and Y-OQ. *Journal of Clinical Psychology*, 67(1), 111-125.
9. Moses, T. (2011). Adolescents' Perspectives About Brief Psychiatric Hospitalization: What is Helpful and What is Not? *Psychiatric Quarterly*, 82(2), 121-137.
10. Neuhaus, Edmund C. (2006). Fixed Values and a Flexible Partial Hospital Program Model. *Harvard Review of Psychiatry*; Jan2006, Vol. 14 Issue 1, p1-14.
11. Priebe, S., Jones, G., McCabe, R., Briscoe, J., Wright, D., Sled, M., et al. (2006). Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care: randomized controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, 188243-249.

P. Partial Hospitalization, Substance-Related Disorder

1. Greenwood, G., Woods, W., Gydish, J., & Bein, E. (2001). Relapse outcomes in a randomized trial of residential and day drug abuse treatment. *Journal of Substance Abuse Treatment*, 20(1), 15-23.
2. Reymann, G., & Danziger, H. (2001). Replacing the last week of a motivational inpatient alcohol withdrawal programme by a day-clinic setting. *European Addiction Research*, 7(2), 56-60.
3. Schaefer, J., Cronkite, R., & Hu, K. (2011). Differential relationships between continuity of care practices, engagement in continuing care, and abstinence among

subgroups of patients with substance use and psychiatric disorders. *Journal of Studies on Alcohol and Drugs*, 72(4), 611-621.

Q. Preamble

1. Gregoire, T., & Burke, A. (2004). The relationship of legal coercion to readiness to change among adults with alcohol and other drug problems. *Journal of Substance Abuse Treatment*, 26(1), 337-343.
2. Hasler, G., Delsignore, A., Milos, G., Buddeberg, C., & Schnyder, U. (2004). Application of Prochaska's transtheoretical model of change to patients with eating disorders. *Journal of Psychosomatic Research*, 57(1), 67-72.
3. Timko, C., & Sempel, J. (2004). Short-term outcomes of matching dual diagnosis patients' symptom severity to treatment intensity. *Journal of Substance Abuse Treatment*, 26(3), 209-218.

R. Psychiatric/Substance-Related Disorder Comorbidity

1. Davis LL, Wisniewski SR, Howland RH, Trivedi MH, Husain MM, Fava M, McGrath PJ, Balasubramani GK, Warden D, Rush AJ. (2010). Does comorbid substance use disorder impair recovery from major depression with SSRI treatment? An analysis of the STAR*D level one treatment outcomes. *Drug Alcohol Depend*. 2010 Mar 1; 107 (2-3):161-70.
2. Gil-Rivas V; Prause J; Grella CE. (2009). Substance use after residential treatment among individuals with co-occurring disorders: the role of anxiety/depressive symptoms and trauma exposure. *Psychology of Addictive Behaviors: Journal of The Society of Psychologists in Addictive Behaviors [Psychol Addict Behav]* 2009 Jun; Vol. 23 (2), pp. 303-14.
3. Grilo, C., Martino, S., Walker, M., Becker, D., Edell, W., & McGlashan, T. (1997). Controlled study of psychiatric comorbidity in psychiatrically hospitalized young adults with substance use disorders. *The American Journal of Psychiatry*, 154(9), 1305-1307.
4. Jaycox, L., Morral, A., & Juvonen, J. (2003). Mental health and medical problems and service use among adolescent substance users. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(6), 701-709.
5. Ostacher, M., Perlis, R., Nierenberg, A., Calabrese, J., Stange, J., Salloum, I., & ... Sachs, G. (2010). Impact of substance use disorders on recovery from episodes of depression in bipolar disorder patients: prospective data from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *The American Journal of Psychiatry*, 167(3), 289-297. Retrieved from EBSCOhost.
6. Parikh, S., LeBlanc, S., & Ovanessian, M. (2010). Advancing bipolar disorder: key lessons from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 55(3), 136-143. Retrieved from EBSCOhost.
7. Prince JD, Akincigil A, Hoover DR, Walkup JT, Bilder S, Crystal S. (2009). Substance abuse and hospitalization for mood disorder among Medicaid beneficiaries. *The American Journal of Public Health*, 99(1), 160-167.

8. Timko, C., Lesar, M., Calvi, N., & Moos, R. (2003). Trends in acute mental health care: comparing psychiatric and substance abuse treatment programs. *The Journal of Behavioral Health Services & Research*, 30(2), 145-160.
9. Timko, C., Sempel, J., & Moos, R. (2003). Models of standard and intensive outpatient care in substance abuse and psychiatric treatment. *Administration and Policy in Mental Health*, 30(5), 417-436.
10. Xafenias, A., Diakogiannis, I., Iacovides, A., Fokas, K., & Kaprinis, G. (2008). Factors affecting hospital length of stay: is substance use disorder one of them? A study in a Greek public psychiatric hospital. *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions*, 17(5), 447-451.

S. Residential, Child & Adolescent

1. Biering, P., & Jensen, V. H. (2011). The Concept of Patient Satisfaction in Adolescent Psychiatric Care: A Qualitative Study. *Journal of Child & Adolescent Psychiatric Nursing*, 24(1), 3-10
2. Curry, J. (2004). Future directions in residential treatment outcome research. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 429-440.
3. Epstein, R. (2004). Inpatient and residential treatment effects for children and adolescents: a review and critique. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 411-428.
4. Hummer, V., Dollard, N., Robst, J., & Armstrong, M. (2010). Innovations in implementation of trauma-informed care practices in youth residential treatment: a curriculum for organizational change. *Child Welfare*, 89(2), 79-95. Retrieved from EBSCOhost.
5. Hussey, D., & Guo, S. (2005). Forecasting length of stay in child residential treatment. *Child Psychiatry and Human Development*, 36(1), 95-111.
6. Leichtman, M. (2006). Residential treatment of children and adolescents: past, present, and future. *The American Journal of Orthopsychiatry*, 76(3), 285-294.
7. McClendon, D. J. (2011). Sensitivity to change of youth treatment outcome measures: a comparison of the CBCL, BASC-2, and Y-OQ. *Journal of Clinical Psychology*, 67(1), 111-125.
8. Moses, T. (2011). Adolescents' Perspectives about Brief Psychiatric Hospitalization: What is Helpful and What is Not? *Psychiatric Quarterly*, 82(2), 121-137.
9. O'Malley, F. (2004). Contemporary issues in the psychiatric residential treatment of disturbed adolescents. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 255-266.
10. Shoaf, T. (2004). Pediatric psychopharmacology for the major psychiatric disorders found in the residential treatment setting. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 327-345.
11. Zelechowski, A. (2013). Traumatized Youth in Residential Treatment Settings: Prevalence, Clinical Presentation, Treatment, and Policy Implications. *Journal Of Family Violence*, 28(7), 639-652. PDF available

T. Residential, General

1. Björgvinsson, T., Hart, A., Wetterneck, C., Barrera, T., Chasson, G., Powell, D., & ... Stanley, M. (2013). Outcomes of specialized residential treatment for adults with obsessive-compulsive disorder. *Journal of Psychiatric Practice*, 19(5), 429-437.
2. Davis, K., Devitt, T., Rollins, A., O'Neill, S., Pavick, D., & Harding, B. (2006). Integrated residential treatment for persons with severe and persistent mental illness: lessons in recovery. *Journal of Psychoactive Drugs*, 38(3), 263-272.
3. Gil-Rivas V; Prause J; Grella CE. (2009). Substance use after residential treatment among individuals with co-occurring disorders: the role of anxiety/depressive symptoms and trauma exposure. *Psychology of Addictive Behaviors: Journal of The Society of Psychologists in Addictive Behaviors [Psychol Addict Behav]* 2009 Jun; Vol. 23 (2), pp. 303-14.
4. Gruber-Baldini, A., Boustani, M., Sloane, P., & Zimmerman, S. (2004). Behavioral symptoms in residential care/assisted living facilities: prevalence, risk factors, and medication management. *Journal of the American Geriatrics Society*, 52(10), 1610-1617.
5. Hawthorne, W., Green, E., Gilmer, T., Garcia, P., Hough, R., Lee, M., et al. (2005). A randomized trial of short-term acute residential treatment for veterans. *Psychiatric Services (Washington, D.C.)*, 56(11), 1379-1386.
6. Samus, Q., Onyike, C., Johnston, D., Mayer, L., McNabney, M., Baker, A., & ... Rosenblatt, A. (2013). 12-month incidence, prevalence, persistence, and treatment of mental disorders among individuals recently admitted to assisted living facilities in Maryland. *International Psychogeriatrics / IPA*, 25(5), 721-731.
7. Subramaniam GA; Lewis LL; Stitzer ML; Fishman MJ. (2004). Depressive symptoms in adolescents during residential treatment for substance use disorders. *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions [Am J Addict]* 2004 May-Jun; Vol. 13 (3), pp. 256-67.
8. Vandevooren, J., Miller, L., & O'Reilly, R. (2007). Outcomes in community-based residential treatment and rehabilitation for individuals with psychiatric disabilities: a retrospective study. *Psychiatric Rehabilitation Journal*, 30(3), 215-217.

U. Residential, Substance-Related Disorder

1. Amodeo, M., Chassler, D., Oettinger, C., Labiosa, W., & Lundgren, L. (2008). Client retention in residential drug treatment for Latinos. *Evaluation and Program Planning*, 31(1), 102-112.
2. Davis, K., Devitt, T., Rollins, A., O'Neill, S., Pavick, D., & Harding, B. (2006). Integrated residential treatment for persons with severe and persistent mental illness: lessons in recovery. *Journal of Psychoactive Drugs*, 38(3), 263-272.
3. Najt, P., Fusar-Poli, P., & Brambilla, P. (2011). Co-occurring mental and substance abuse disorders: A review on the potential predictors and clinical outcomes. *Psychiatry Research*, 186(2-3), 159-164. Retrieved from EBSCO host.

4. Laffaye, C., McKellar, J., Ilgen, M., & Moos, R. (2008). Predictors of 4-year outcome of community residential treatment for patients with substance use disorders. *Addiction (Abingdon, England)*, 103(4), 671-680.
5. Schaefer, J., Cronkite, R., & Hu, K. (2011). Differential relationships between continuity of care practices, engagement in continuing care, and abstinence among subgroups of patients with substance use and psychiatric disorders. *Journal of Studies on Alcohol and Drugs*, 72(4), 611-621.
6. Subramaniam GA; Lewis LL; Stitzer ML; Fishman MJ. (2004). Depressive symptoms in adolescents during residential treatment for substance use disorders. *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions [Am J Addict]* 2004 May-Jun; Vol. 13 (3), pp. 256-67.
7. Swendsen, J., Conway, K., Degenhardt, L., Glantz, M., Jin, R., Merikangas, K., & ... Kessler, R. (2010). Mental disorders as risk factors for substance use, abuse and dependence: results from the 10-year follow-up of the National Comorbidity Survey. *Addiction (Abingdon, England)*, 105(6), 1117-1128. Retrieved from EBSCOhost.

V. Substance-Related Disorders, General

1. Grella, C., Stein, J., Weisner, C., Chi, F., & Moos, R. (2010). Predictors of longitudinal substance use and mental health outcomes for patients in two integrated service delivery systems. *Drug And Alcohol Dependence*, 110(1-2), 92-100. Retrieved from EBSCOhost.
2. Longinaker, N. (2014). Effect of criminal justice mandate on drug treatment completion in women. *American Journal Of Drug & Alcohol Abuse*, 40(3), 192-199.
3. McCarty, D., & Argeriou, M. (2003). The Iowa Managed Substance Abuse Care Plan: access, utilization, and expenditures for Medicaid recipients. *The Journal of Behavioral Health Services & Research*, 30(1), 18-25.
4. Frydrych, L., Greene, B., Blondell, R., & Purdy, C. (2009). Self-help program components and linkage to aftercare following inpatient detoxification. *Journal of Addictive Diseases*, 28(1), 21-27.

W. Suicide

1. Bhatia, S., Rezac, A., Vitiello, B., Sitorius, M., Buehler, B., & Kratochvil, C. (2008). Antidepressant prescribing practices for the treatment of children and adolescents. *Journal of Child and Adolescent Psychopharmacology*, 18(1), 70-80.
2. Blader, J. (2006). Pharmacotherapy and post discharge outcomes of child inpatients admitted for aggressive behavior. *Journal of Clinical Psychopharmacology*, 26(4), 419-425.
3. Bridge, J., Iyengar, S., Salary, C., Barbe, R., Birmaher, B., Pincus, H., et al. (2007). Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment: a meta-analysis of randomized controlled trials. *JAMA: The Journal of the American Medical Association*, 297(15), 1683-1696.
4. Emslie, G., Kratochvil, C., Vitiello, B., Silva, S., Mayes, T., McNulty, S., et al. (2006). Treatment for Adolescents with Depression Study (TADS): safety results. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(12), 1440-1455.

5. Friedman, R., & Leon, A. (2007). Expanding the black box - depression, antidepressants, and the risk of suicide. *The New England Journal of Medicine*, 356(23), 2343-2346.
6. Gibbons, R., Hur, K., Bhaumik, D., & Mann, J. (2006). The relationship between antidepressant prescription rates and rate of early adolescent suicide. *The American Journal of Psychiatry*, 163(11), 1898-1904.
7. Hammad, T., Laughren, T., & Racoosin, J. (2006). Suicidality in pediatric patients treated with antidepressant drugs. *Archives of General Psychiatry*, 63(3), 332-339.
8. Hoyer, E., Olesen, A., & Mortensen, P. (2004). Suicide risk in patients hospitalized because of an affective disorder: a follow-up study, 1973-1993. *Journal of Affective Disorders*, 78(3), 209-217.
9. Huey, S., Henggeler, S., Rowland, M., Halliday-Boykins, C., Cunningham, P., Pickrel, S., et al. (2004). Multisystem therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(2), 183-190.
10. Huth-Bocks, A., Kerr, D., Ivey, A., Kramer, A., & King, C. (2007). Assessment of psychiatrically hospitalized suicidal adolescents: self-report instruments as predictors of suicidal thoughts and behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(3), 387-395.
11. Kennedy, S., Baraff, L., Suddath, R., & Asarnow, J. (2004). Emergency department management of suicidal adolescents. *Annals of Emergency Medicine*, 43(4), 452-460.
12. Leon, A., Marzuk, P., Tardiff, K., Bucciarelli, A., Markham Piper, T., & Galea, S. (2006). Antidepressants and youth suicide in New York City, 1999-2002. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(9), 1054-1058.
13. Nemeroff, C., Kalali, A., Keller, M., Charney, D., Lenderts, S., Cascade, E., et al. (2007). Impact of publicity concerning pediatric suicidality data on physician practice patterns in the United States. *Archives of General Psychiatry*, 64(4), 466-472.
14. Posner, K., Oquendo, M., Gould, M., Stanley, B., & Davies, M. (2007). Columbia Classification Algorithm of Suicide Assessment (C-CASA): classification of suicidal events in the FDA's pediatric suicidal risk analysis of antidepressants. *The American Journal of Psychiatry*, 164(7), 1035-1043.
15. Ries, R., Yuodelis-Flores, C., Comtois, K., Roy-Byrne, P., & Russo, J. (2008). Substance-induced suicidal admissions to an acute psychiatric service: characteristics and outcomes. *Journal of Substance Abuse Treatment*, 34(1), 72-79.
16. Simon, G., Savarino, J., Operskalski, B., & Wang, P. (2006). Suicide risk during antidepressant treatment. *The American Journal of Psychiatry*, 163(1), 41-47.

X. Supervised Living, Psychiatric, Adult

1. Browne, G., Courtney, M., & Meehan, T. (2004). Type of housing predicts rate of readmission to hospital but not length of stay in people with schizophrenia on the Gold Coast in Queensland. *Australian Health Review: A Publication of the Australian Hospital Association*, 27(1), 65-72.

Y. Supervised Living, Psychiatric, Child & Adolescent

1. Biering, P., & Jensen, V. H. (2011). The Concept of Patient Satisfaction in Adolescent Psychiatric Care: A Qualitative Study. *Journal of Child & Adolescent Psychiatric Nursing*, 24(1), 3-10.
2. McClendon, D. J. (2011). Sensitivity to change of youth treatment outcome measures: a comparison of the CBCL, BASC-2, and Y-OQ. *Journal of Clinical Psychology*, 67(1), 111-125.

Z. Supervised Living, Substance-Related Disorder

1. Nuttbrock, L., Rahav, M., Rivera, J., & Ng-Mak, D. (1999). Depressive symptoms and mentally ill chemical abusers' perception of the treatment environment in residential settings. *Addictive Behaviors*, 24(1), 139-144.

AA. Violence & Aggression

1. Edwards DW; Scott CL; Yarvis RM; Paizis CL; Panizzon MS. (2003). *Violence and Victims [Violence Vict]* 2003 Feb; Vol. 18 (1), pp. 3-14.
2. Stuart GL; Moore TM; Ramsey SE; Kahler CW. (2003). Relationship aggression and substance use among women court-referred to domestic violence intervention programs. *Addictive Behaviors [Addict Behav]* 2003 Dec; Vol. 28 (9), pp. 1603-10.

BB. Outpatient Treatment

1. Bartak, A., Andrea, H., Spreeuwenberg, M., Ziegler, U., Dekker, J., Rossum, B., & ... Emmelkamp, P. (2011). Effectiveness of outpatient, day hospital, and inpatient psychotherapeutic treatment for patients with cluster B personality disorders. *Psychotherapy and Psychosomatics*, 80(1), 28-38.
2. Eisen, S., Bottonari, K., Glickman, M., Spiro, A., Schultz, M., Herz, L., & ... Rofman, E. (2011). The incremental value of self-reported mental health measures in predicting functional outcomes of veterans. *The Journal of Behavioral Health Services & Research*, 38(2), 170-190.
3. Fossum, S., Handegård, B., Martinussen, M., Mørch, W. (2008). Psychosocial interventions for disruptive and aggressive behavior in children and adolescents. *European Child & Adolescent Psychiatry*; Oct2008, Vol. 17 Issue 7, p438-45.
4. Mensinger, JL; Diamond, GS; Kaminer, Y; Wintersteen, MB. (2006). Adolescent and Therapist Perception of Barriers to Outpatient Substance Abuse Treatment. *American Journal on Addictions*; Dec2006 Supplement, Vol. 15, p16-25
5. Pfeiffer, P., Ganoczy, D., Bowersox, N., McCarthy, J., Blow, F., & Valenstein, M. (2011). Depression care following psychiatric hospitalization in the Veterans Health Administration. *The American Journal Of Managed Care*, 17(9), e358-e364.
6. Sinyor, M., Schaffer, A., & Levitt, A. (2010). The sequenced treatment alternatives to relieve depression (STAR*D) trial: A review. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 55(3), 126-135. Retrieved from EBSCOhost.

7. van der Voort, T., van Meijel, B., Goossens, P., Renes, J., Beekman, A., & Kupka, R. (2011). Collaborative care for patients with bipolar disorder: a randomized controlled trial. *BMC Psychiatry*, 11133.

CC. Psychological Testing

1. Barkley, R. A. (2006). *Attention-Deficit Hyperactivity Disorder: A Handbook for diagnosis and treatment* (3rd Ed.). New York: Guilford Press.
2. Cincinnati Children's Hospital Medical Center. *Evidence based clinical practice guideline for outpatient evaluation and management of attention-deficit/hyperactivity disorder*. Cincinnati (OH) : Cincinnati Children's Hospital Medical Center; 2004 Apr 30 :1-23.
3. Hunsley, J., & Mash, E. (2007). Evidence-based assessment. *Annual Review of Clinical Psychology*, 329-51.
4. Murphy, L. L., Spies, R. A. & Plake, B.S. (Eds.) *Tests in print VII: An index to tests, test reviews, and the literature on specific tests*. Lincoln, Neb. : Buros Institute of Mental Measurements, University of Nebraska-Lincoln, (2006).
5. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder (2007). *Journal of American Academy Child and Adolescent Psychiatry*, 46(7). 894-921.
6. Root, R. W. & Resnick, R. J. (2003). An update on the diagnosis and treatment of Attention-Deficit/Hyperactivity Disorder in children. *Professional Psychology: Research and Practice*, 34 (1), 34-41.
7. Standards for Educational and Psychological Testing. Revised (1999) Washington, D.C.: AERA Publications. p. 48.

DD. Electroconvulsive Therapy

1. American Psychiatric Association. (2001). *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging*. Arlington, VA: American Psychiatric Press.
2. Dew, R., & McCall, W. (2004). Efficiency of outpatient ECT. *The Journal of ECT*, 20(1), 24-25.
3. Eranti, S., Mogg, A., Pluck, G., Landau, S., Purvis, R., Brown, R.G., ... McLoughlin, D.M. (2007). A Randomized, Controlled Trial with 6-Month Follow-Up of Repetitive Transcranial Magnetic Stimulation and Electroconvulsive Therapy for Severe Depression. *Am Journal Psychiatry*, 164(1), 73-81.
4. Frederikse, M., Petrides, G., & Kellner, C. (2006). Continuation and maintenance electroconvulsive therapy for the treatment of depressive illness: a response to the National Institute for Clinical Excellence report. *The Journal of ECT*, 22(1), 13-17.
5. Hausner, L., Damian, M., Sartorius, A., & Frölich, L. (2011). Efficacy and cognitive side effects of electroconvulsive therapy (ECT) in depressed elderly inpatients with coexisting mild cognitive impairment or dementia. *The Journal of Clinical Psychiatry*, 72(1), 91-97.

6. Kellner, C., Fink, M., Knapp, R., Petrides, G., Husain, M., Rummans, T., et al. (2005). Relief of expressed suicidal intent by ECT: a consortium for research in ECT study. *The American Journal of Psychiatry*, 162(5), 977-982.
7. Loo, C., Katalinic, N., Mitchell, P., & Greenberg, B. (2011). Physical treatments for bipolar disorder: a review of electroconvulsive therapy, stereotactic surgery and other brain stimulation techniques. *Journal of Affective Disorders*, 132(1-2), 1-13.
8. New York State Office of Mental Health. Electroconvulsive Therapy Review Guidelines. <http://www.omh.state.ny.us/omhweb/resources/>. Last modified 9/16/2008.
9. Rasmussen, K., Mueller, M., Kellner, C., Knapp, R., Petrides, G., Rummans, T., et al. (2006). Patterns of psychotropic medication use among patients with severe depression referred for electroconvulsive therapy: data from the Consortium for Research on Electroconvulsive Therapy. *The Journal of ECT*, 22(2), 116-123.
10. Sackeim HA, Dillingham EM, Prudic J, Cooper T, McCall WV, Rosenquist P, Isenberg K, Garcia K, Mulsant BH, Haskett RF. (2009). Effect of concomitant pharmacotherapy on electroconvulsive therapy outcomes: short-term efficacy and adverse effects. *Arch Gen Psychiatry*. 2009 Jul; 66 (7):729-37.
11. Silver JM, Yudofsky SC, Hurowitz GI. 2008. Psychopharmacology and electroconvulsive therapy. In Textbook of Psychiatry, second edition. Arlington, VA: American Psychiatric Press.

EE. 23-Hour Observation

1. Clinical Guidelines for the State of Nebraska Medicaid Managed Care Plan. (Revised 10/2003). 23-Hour Crisis Observation

FF. Buprenorphine Maintenance

1. Albright, J., Ciaverelli, R., Essex, A., Tkacz, J., Ruetsch, C. (2010). Psychiatrist Characteristics that Influence Use of Buprenorphine Medication-Assisted Treatment. *Journal of Addiction Medicine*; 21 January 2010. 10.1097
2. Alford, D., Compton, P., & Samet, J. (2006). Acute pain management for patients receiving maintenance methadone or Buprenorphine therapy. *Annals of Internal Medicine*, 144(2), 127-134.
3. Boothby, L., & Doering, P. (2007). Buprenorphine for the treatment of opioid dependence. *American Journal of Health-System Pharmacy: AJHP: Official Journal of The American Society of Health-System Pharmacists*, 64(3), 266-272.
4. Caldiero, RM; Parran, TV Jr; Adelman, CL; Piche, B. (2006) Inpatient initiation of Buprenorphine maintenance vs. detoxification: can retention of opioid-dependent patients in outpatient counseling be improved? *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions [Am J Addict]* 2006 Jan-Feb; Vol. 15 (1), pp. 1-7.
5. Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement

Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

6. Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
7. Donaher, P., & Welsh, C. (2006). Managing opioid addiction with Buprenorphine. *American Family Physician*, 73(9), 1573-1578.
8. Fiellin, D., Kleber, H., Trumble-Hejduk, J., McLellan, A., & Kosten, T. (2004). Consensus statement on office-based treatment of opioid dependence using Buprenorphine. *Journal of Substance Abuse Treatment*, 27(2), 153-159.
9. Fiellin, D., Pantalon, M., Chawarski, M., Moore, B., Sullivan, L., O'Connor, P., et al. (2006). Counseling plus Buprenorphine-Naloxone maintenance therapy for opioid dependence. *The New England Journal of Medicine*, 355(4), 365-374.
10. Fudala, P., Bridge, T., Herbert, S., Williford, W., Chiang, C., Jones, K., et al. (2003). Office-based treatment of opiate addiction with a sublingual-tablet formulation of Buprenorphine and Naloxone. *The New England Journal of Medicine*, 349(10), 949-958.
11. Gandhi, D., Jaffe, J., McNary, S., Kavanagh, G., Hayes, M., & Currens, M. (2003). Short-term outcomes after brief ambulatory opioid detoxification with Buprenorphine in young heroin users. *Addiction (Abingdon, England)*, 98(4), 453-462.
12. Gerra, G., Borella, F., Zaimovic, A., Moi, G., Bussandri, M., Bubici, C., et al. (2004). Buprenorphine versus methadone for opioid dependence: predictor variables for treatment outcome. *Drug and Alcohol Dependence*, 75(1), 37-45.
13. Horspool, MJ; Seivewright, N; Armitage, CJ; Mathers, N. (2008). Post-Treatment Outcomes of Buprenorphine Detoxification in Community Settings: A Systematic Review. *European Addiction Research*; 2008, Vol. 14 Issue 4, p179-185.
14. Kakko, J., Grönbladh, L., Svanborg, K., von Wachenfeldt, J., Rück, C., Rawlings, B., et al. (2007). A stepped care strategy using Buprenorphine and methadone versus conventional methadone maintenance in heroin dependence: a randomized controlled trial. *The American Journal of Psychiatry*, 164(5), 797-803.
15. Katz EC; Schwartz RP; King S; Highfield DA; O'Grady KE; Billings T; Gandhi D; Weintraub E; Glovinsky D; Barksdale W; Brown BS. (2009). Brief vs. extended Buprenorphine detoxification in a community treatment program: engagement and short-term outcomes. *The American Journal of Drug and Alcohol Abuse [Am J Drug Alcohol Abuse]* 2009; Vol. 35 (2), pp. 63-7.

16. Manlandro, J. (2007). Using Buprenorphine for outpatient opioid detoxification. *The Journal of the American Osteopathic Association*, 107(9 Suppl 5), ES11-ES16.
17. Matson, S., Hobson, G., Abdel-Rasoul, M., & Bonny, A. (2014). A retrospective study of retention of opioid-dependent adolescents and young adults in an outpatient buprenorphine/naloxone clinic. *Journal Of Addiction Medicine*, 8(3), 176-182.
18. Mitchell, S.G., Gryczynski, J., Schwartz, R.P., O'Grady, K.E., Olsen, Y.K., Jaffe, J.H. (2013). A randomized trial of intensive outpatient (IOP) vs. standard outpatient (OP) buprenorphine treatment for African Americans. *Drug and Alcohol Dependence*, 128: 222-229.
19. Montoya, I., Gorelick, D., Preston, K., Schroeder, J., Umbricht, A., Cheskin, L., et al. (2004). Randomized trial of Buprenorphine for treatment of concurrent opiate and cocaine dependence. *Clinical Pharmacology and Therapeutics*, 75(1), 34-48.
20. Neumann, A., Blondell, R., Azadfard, M., Nathan, G., & Homish, G. (2013). Primary care patient characteristics associated with completion of 6-month buprenorphine treatment. *Addictive Behaviors*, 38(11), 2724-2728.
21. Robinson, S. (2006). Buprenorphine-containing treatments: place in the management of opioid addiction. *CNS Drugs*, 20(9), 697-712.
22. Schottenfeld, R., Chawarski, M., Pakes, J., Pantalon, M., Carroll, K., & Kosten, T. (2005). Methadone versus Buprenorphine with contingency management or performance feedback for cocaine and opioid dependence. *The American Journal of Psychiatry*, 162(2), 340-349.
23. Sittambalam, C., Vij, R., & Ferguson, R. (2014). Buprenorphine Outpatient Outcomes Project: can Suboxone be a viable outpatient option for heroin addiction?. *Journal Of Community Hospital Internal Medicine Perspectives*, 4doi:10.3402/jchimp.v4.22902
24. Woody GE, Poole SA, Subramaniam G, Dugosh K, Bogenschutz M, Abbott P, Patkar A, Publicker M, McCain K, Potter JS, Forman R, Vetter V, McNicholas L, Blaine J, Lynch KG, Fudala P. (2008). Extended vs. short-term buprenorphine-naloxone for treatment of opioid-addicted youth: a randomized trial. *JAMA*. 2008 Nov 5; 300(17):2003-11.

GG. Applied Behavior Analysis (ABA) Treatments

1. Autism Spectrum Disorders (Pervasive Developmental Disorders), Accessed National Institutes of Mental Health website www.nimh.nih.gov on November 15, 2005.
2. Behavior Analysis Services to Individuals with Autism or Related Disorders. Accessed Association for Science in Autism Treatment website www.asatonline.org on November 15, 2005.

3. Cohen H, Amerine-Dickens, Smith T. Early Intensive Behavioral Treatment: Replication of the UCLA Model in a Community Setting. *Developmental and Behavioral Pediatrics*. Vol. 27, No. 2, April 2006.
4. Description of Applied Behavioral Analysis. Accessed Association for Science in Autism Treatment website www.asatonline.org on November 15, 2005.
5. Eikeseth S, Smith T, Jahr E, Eldevik S. Intensive behavioral treatment at school for 4- to 7-year-old children with autism. A 1-year comparison controlled study. *Behavior Modification* 2002 Jan; 26 (1):49-68.
6. Eikeseth S, Smith T, Jahr E, Eldevik. Outcome for Children with Autism who began Intensive Behavioral Treatment between Ages 4 and 7. A Comparison Controlled Study, *Behavior Modification*, Volume 31, Number 3, May 2007, 264-278.
7. Eikeseth S. Outcome of comprehensive psycho-educational interventions for young children with autism. *Res Dev Disabl* (2008), doi: 10.1016/j.ridd.2008.02.003.
8. Eldevik S, Hastings RP, Hughes JC, Jahr E, Eikeseth S, Cross S. Meta-Analysis of Early Intensive Behavioral Intervention for Children with Autism. *Journal of Clinical child and Adolescent Psychology*, 38(3), 439, 450, 2009.
9. Howard JS, Sparkman CR, Cohen HG, et al. A comparison of intensive behavior analytic and eclectic treatments for young children with autism. *Research in Developmental Disabilities*, Jul-Aug; 26 (4):359-83, 2005.
10. Lovaas, O. I., Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 55, 3-9, 1987.
11. Matson JL, Benavidez DA, Compton LS, et al. Behavioral treatment of autistic persons: a review of research from 1980 to the present. *Research in Developmental Disabilities*, 1996 Nov-Dec;17 (6):433-65.
12. Mental Health: Report of the Surgeon General, Chapter 3, Other Mental Disorders in Children and Adolescents, 1999.
13. Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Autism and Other Pervasive Developmental Disorders, American Academy of Child and Adolescent Psychiatry, 1999.
14. Rogers SJ. Empirically supported comprehensive treatments for young children with autism. *Journal of Clinical Child Psychology*, 1998 Jun; 27(2):168-79.
15. Myers SM, Plauche Johnson C and the Council on Children with Disabilities. Management of Children with Autism Spectrum Disorders. *Pediatrics* 2007: 120; 1162-1182.
16. Ozonoff S, Rogers S, Hendren RL. *Autism Spectrum Disorders A Research Review for Practitioners*. (American Psychiatric Publishing, Inc., 2003). 146-148.

17. Remington B, Hastings RP, Kovshoff H, degli Espinosa F, Jahr E, Brown T, Alsford P, Lemaic M, Ward N. Early Intensive Behavioral Intervention: Outcomes for children with autism and their parents after two years. *American Journal on Mental Retardation*, Volume 112, Number 6L 418-438, November 2007.
18. Sallow GO, Graupner T. Intensive Behavioral Treatment for Children With Autism: Four-Year Outcome and Predictors. *American Journal on Mental Retardation*. Volume 110, Number 6:417-438, November 2005.
19. Screibman Laura, Intensive Behavioral/Psychoeducational treatments for Autism: Research needs and future directions, *Journal of Autism and Developmental Disorders*, Vol. 30, No. 5, 2000.
20. Shoen, Alexis, What potential does the applied behavioral analysis approach have for the treatment of children and youth with autism? *Journal of Instructional Psychology*, June 2003.
21. Smith T, Groen AD, Wynn JW. Randomized Trial of Intensive Early Intervention for Children with Pervasive Developmental Disorder. *American Journal on Mental Retardation*, 2000, Vol. 195, No. 4, 269-285.
22. Special Report: Early Intensive Behavioral Intervention Based on Applied Behavior Analysis among Children with Autism Spectrum Disorders. *TEC Assessment Program* Volume 23, No. 9, February 2009.
23. Spreckley M, Boyd R. Efficacy of Applied Behavioral Intervention in Preschool Children with Autism for Improving Cognitive, Language, and Adaptive Behavior: A Systematic Review and Meta-analysis. *J Pediatr*, published online 28 October 2008 at <http://www.jpeds.com/>.
24. Steege MW, Mace FC, Perry L and Longenecker H. Applied Behavior Analysis: Beyond Discrete Trial Teaching. *Psychology in the Schools*, Vol. 44(1): 2007.
25. The Puzzle of Autism. National Education Association. 1st Edition. 2006.
26. Thompson, T. (2014) Autism and Behavior Analysis, in The Wiley Blackwell Handbook of Operant and Classical Conditioning (eds F. K. McSweeney and E. S. Murphy), John Wiley & Sons, Ltd, Oxford, UK.
27. Weitlauf AS, McPheeters ML, Peters B, Sathe N, Travis R, Aiello R, Williamson E, Veenstra-VanderWeele J, Krishnaswami S, Jerome R, Warren Z. Therapies for Children With Autism Spectrum Disorder: Behavioral Interventions Update. Comparative Effectiveness Review No. 137. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-2012-00009-I.) AHRQ Publication No. 14-EHC036-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2014. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

HH. Transcranial Magnetic Stimulation (TMS)

1. Avery DH, Holtzheimer PE, Fawaz W, Russo, Neumaier J, Dunner DL, Haynor DR, Claypoole KH, Wajdik C, Roy-Byrne P. A Controlled Study of Repetitive Transcranial Magnetic Stimulation in Medication-Resistant Major Depression. *Biol Psychiatry* 2006; 59: 187-194.
2. Avery DH, Isenberg KE, Sampson SM, Janicak PG, Lisanby SH, Maixner DF, Loo C, Thase MR, Demitrack MA, George MS. Transcranial magnetic Stimulation in the Acute Treatment of Major Depressive Disorder: Clinical Response in an Open-Label Extension Trial. *J Clin Psychiatry* 69:3 March 2008.
3. Burt, Lisanby SH, Sackeim HA, Neuropsychiatric applications of transcranial magnetic stimulation : a meta analysis. *Int J Neuropsychopharmacol*, 2002, 5: 73-103.
4. Carpenter LL, Janicak PG, Aaronson ST, Boyadjis T, Brock DG, Cook IA, Dunner DL, Lanocha K, Solvason HB, Demitrack MA. Depression and Anxiety 29: 587-596 (2012).
5. Carpenter L, Neurostimulation in resistant depression. *Journal of Psychopharmacology*, 2006, 20 (3): 35-40.
6. Cohen RB, Boggio PS, Fregni F. Risk Factors for Relapse after Remission with Repetitive Transcranial Magnetic Stimulation for the Treatment of Depression. *Depression and Anxiety* 0: 1-7 (2009).
7. Connolly KR, Helmer A, Cristancho MA, Cristancho P, O'Reardon JP. Effectiveness of Transcranial Magnetic Stimulation in Clinical Practice Post-FDA Approval in the United States: Results Observed With the First 100 Consecutive Cases of Depression at an Academic Medical Center. *J Clin Psychiatry* 73:4, April 2012.
8. Couturier JL, Efficacy of rapid-rate repetitive transcranial magnetic stimulation in the treatment of depression: a systematic review and meta-analysis. *J Psychiatry Neurosci*, 2005, 30: 83-90.
9. Demirtas-Tatlided A, Mechanic-Hamilton D, Press DA, Pearlman C, Stern WM, Thall M, Pascual-Leone A. An Open-Label, Prospective Study of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Long-Term Treatment of Refractory Depression: Reproducibility and Duration of the Antidepressant Effect in Medication-Free Patients. *J Clin Psychiatry* 69:6, June 2008.
10. Demitrack Mark A., MD, Examining the Safety and Effectiveness of Transcranial Magnetic Stimulation for Depression, *Psychiatric Annals*, Volume 35, Number 2, February 2005.
11. Demitrack MA, Thase ME. Clinical significance of Transcranial Magnetic Stimulation (TMS) in the Treatment of Pharmacoresistent Depression: Synthesis of Recent Data. *Psychopharmacology Bulletin*. 2009; 42 (2): 5-38.
12. Demitrack MA. NeuroStar Transcranial Magnetic Stimulation (TMS) Therapy for Major Depressive Disorder (PowerPoint presentation), July 27, 2010.

13. Eranti S, Mogg A, Pluck G, et al. A randomized, controlled trial with 6-month follow-up of repetitive transcranial magnetic stimulation and electroconvulsive therapy for severe depression. *Am J Psychiatry*. 2007 Jan; 164 (1): 73-81.
14. Eranti, S., Mogg, A., Pluck, G., Landau, S., Purvis, R. Brown, R.G., ... McLoughlin, D.M. (2007). A Randomized, Controlled Trial with 6-Month Follow-Up of Repetitive Transcranial Magnetic Astimulation and Electrconvulsive Therapy for Severe Depression. *Am Journal Psychiatry*, 164(1), 73-81.
15. FDA Clears Neurostar TMS Therapy for the Treatment of Depression Press Release. Accessed website on November 11, 2008 www.neuronetics.com.
16. FDA Executive Summary. 501(k) pre-market notification submission, K061053, submitted by Neuronetics, Inc. to the Restorative Devices Branch of the Division of General, Restorative and Neurological Devices at the Center for Devices and Radiological Health of the Food and Drug Administration (FDA).
17. FDA Panel Recommends Against Depression-Treatment Device. *Psychiatric News* March 2, 2007, Volume 42, Number 5, page 2.
18. Fitzgerald PB, Benitez J, de Castella A, et al. A randomized, controlled trial of sequential bilateral repetitive transcranial magnetic stimulation for treatment-resistant depression. *Am J Psychiatry*. 2006 Jan; 163(1): 88-94.
19. Fitzgerald PB, Daskalakis ZJ. The Use of Repetitive Transcranial magnetic Stimulation and Vagal Nerve Stimulation in the Treatment of Depression. *Curr Opin Psychiatry* 2008; 21 (1): 25-29. Accessed website on October 13, 2008 www.medscape.com.
20. Fitzgerald Paul B, MBBS, MPM, Transcranial Magnetic Stimulation Effective for Medication-Resistant Major Depression. *Arch Gen Psychiatry*. 2003; 60: 1002-1008. Accessed website www.medscape.com, March 29, 2005.
21. Fregni F, Repetitive Transcranial Magnetic Stimulation Helpful for Depression in Parkinson's disease, *J Neurol Neurosurg Psychiatry*. 2004; 75: 1171-1174. Accessed website www.medscape.com on March 29, 2005.
22. Garcia KS, Flynn P, Pierce KJ, Caudle M. Repetitive transcranial magnetic stimulation treats postpartum depression. DOI: 10.1016/j.brs.2009.06.001.
23. Gaynes N Bradley, MD, MPH, et al. Repetative Transcranial Magnetic Stimulation for Treatment-Resistant Depression: A Systematic Review and Meta Analysis. *J Clin Psychiatry*. 75:5, May 2014: 477-489.
24. George MS, Lisanby SH, Avery D, McDonald WM, Durkalski V, Pavlicova M, Anderson B, Nahas Z, Bulow P, Zarkowski P, Holtzheimer PE, Schwartz T, Sackeim HA.. Daily Left Prefrontal Transcranial magnetic Stimulation Therapy for Major Depressive Disorder. *Arch Gen Psychiatry*/Vol. 67 (No. 5), May 2010.
25. Gershon AA, Dannon PN, Grunhaus L. Transcranial magnetic stimulation in the treatment of depression. *Am J Psychiatry*. 2003 May; 160 (5): 835-45.
26. Grunhaus L, Dannon PN, et al. Repetitive transcranial magnetic stimulation is as effective as electroconvulsive therapy in the treatment of nondelusional major depressive disorder: an open study. *Biol Psychiatry*, 200 Feb 15; 47 (4): 314-24.

27. Grunhaus L, Schreiber S, et al. A randomized controlled comparison of electroconvulsive therapy and repetitive transcranial magnetic stimulation in severe and resistant nonpsychotic major depression. *Biol Psychiatry*, 2003 Feb 15; 53 (4): 324-31.
28. Guidance for Industry and FDA Staff - Class II Special Controls Guidance Document: Repetitive Transcranial Magnetic Stimulation (rTMS) Systems. July 26, 2011. Retrieved from <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm265269.htm>
29. Hausmann A, Kemmler G, et al. No benefit derived from repetitive transcranial magnetic stimulation in depression: a prospective, single centre, randomized, double blind, sham controlled “add on” trial. *J Neurol Neurosurg Psychiatry*. 2004 Feb; 75 (2): 320-2.
30. Holtzheimer PEIII, Russo J, Avery DH, A meta-analysis of repetitive transcranial magnetic stimulation in the treatment of depression. *Psychopharmacol Bulletin*, 2001, 35: 149-169.
31. Holtzheimer PE, Russo J, et al. Shorter duration of depressive episode may predict response to repetitive transcranial magnetic stimulation. *Depress Anxiety*. 2004; 19 (1): 24-30.
32. Janicak Philip G., MD, Dowd Shiela M., Ph.D. et al., The Potential Role of Repetitive Transcranial Magnetic Stimulation in Treating Severe Depression, *Psychiatric Annals*, Volume 35, Number 2, February 2005.
33. Janicak PG, Dowd SM et al. Repetitive transcranial magnetic stimulation versus electroconvulsive therapy for major depression: preliminary results of a randomized trial. *Biol Psychiatry*. 2002 April 15; 51 (8); 659-67.
34. Janicak PG, Nahas Z, Lisanby SH, Solvason HB, Sampson SM, McDonald WM, Marangell LB, Rosenquist P, McCall WV, Kimball J, O'Reardon JP, Loo C, Husain MH, Krystak A, Gilmer W, Dowd SM, Demitrack MA, Schatzberg AF. Durability of clinical benefit with transcranial magnetic stimulation (TMS) in the treatment of pharmacoresistent major depression: assessment of relapse during a 6-month, multi-site, open-label study. *Brain Stimulation* 2010 doi:10.1016/j.brs.2010.07.003.
35. Jorge R, Moser DJ, Acton L, Robinson RG. Treatment of Vascular Depression Using Repetitive Transcranial Magnetic Stimulation. *Arch Gen Psychiatry*/vol. 65 (No. 3) mar 2008.
36. Jorge RE, Robinson RG, et al. Repetitive transcranial magnetic stimulation as treatment of post stroke depression: a preliminary study. *Biol Psychiatry*. 2004 Feb 15; 55 (4): 398-405.
37. Karsen, E., Watts, B., & Holtzheimer, P. (2014). Review of the effectiveness of transcranial magnetic stimulation for post-traumatic stress disorder. *Brain Stimulation*, 7(2), 151-157.
38. Koerselman F, Laman DM, et al. A 3-month, follow-up, randomized, placebo-controlled study of repetitive transcranial magnetic stimulation in depression. *J Clin Psychiatry*. 2004 Oct; 65(10); 1323-8.

39. Kozel Frank Andrew, MD, MS, Nahas Ziad, MD et al., Functional Magnetic Resonance Imaging and Transcranial Magnetic Stimulation for Major Depression, *Psychiatric Annals*, Volume 35, Number 2, February 2005.
40. Kozel FA, George MS, Meta-analysis of left prefrontal repetitive transcranial magnetic stimulation (rTMS) to treat depression. *J Psychiatr Pract* , 2002, 8: 270-275.
41. Lisanby SH, Husain MM, Rosenquist PB, Maixner D Gutierrez R, Krystal A, Gilmer W, Marangell LB, Aaronson S, Daskalakis ZJ, Canterbury R, Richelson E, Sackeim HA Griorg MS. Daily Left Prefrontal Repetitive Transcranial Magnetic Stimulation in the Acute Treatment of Major Depression: Clinical Predictors of Outcome in a Multisite, Randomized Controlled Clinical Trial. *Neuropsychopharmacology* (2008), 1-13.
42. Lisanby SH, Husain MM, Rosenquist PB, Maixner D Gutierrez R, Krystal A, Gilmer W, Marangell LB, Aaronson S, Daskalakis ZJ, Canterbury R, Richelson E, Sackeim HA George MS. Daily Left Prefrontal Repetitive Transcranial Magnetic Stimulation in the Acute Treatment of Major Depression: Clinical Predictors of Outcome in a Multisite, Randomized Controlled Clinical Trial. *Neuropsychopharmacology* (2009), 34, 522-534.
43. Market Notification K083538 NeuroStar TMS System. Accessed website on November 11, 2008 http://www.accessdata.fda.gov/cdrh_docs/pdf8/K083538.pdf
44. Martin JL, Barbanoj MJ, , Repetitive transcranial magnetic stimulation for the treatment of depression. Systematic review and meta-analysis. *Br J Psychiatry*. 2003 Jun; 182: 480-91.
45. McNamara B, Ray JL, Arthurs OJ, Boniface S, Transcranial magnetic stimulation for depression and other psychiatric disorders, *Psychol Med*, 2001, 31: 1141-1146.
46. Milne, David, Sever Depression Responds to Low-Frequency Stimulation. *Psychiatric News*, May 7, 2004.
47. Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. *Br J Psychiatry* 1979; 134: 382-389.
48. Mosimann UP, Schmitt W, et al. Repetitive transcranial magnetic stimulation: a putative add-on treatment for major depression in elderly patients. *Psychiatry Res*. 2004 April 30; 126(2): 123-33.
49. Nahas Z, Li X, et al. Safety and benefits of distance-adjusted prefrontal transcranial magnetic stimulation in depressed patients 55-75 years of age: a pilot study. *Depress Anxiety*. 2004; (4): 249-56.
50. O'Reardon JP, Blumner KH, Peshek AD, et al., Long-Term Maintenance Therapy for Major Depressive Disorder With rTMS. *J Clin Psychiatry* 66:12, December 2005.
51. O'Reardon JP, Solvason HB, Janicak PG, Sampson S, Isenberg KE, Nahas Z, McDonald WM, Avery D, Fitzgerald PB, Loo C, Demitrack MA, George MS, Sackeim HA. Efficacy and Safety of Transcranial Magnetic Stimulation in the Acute Treatment of Major Depression: A Multisite Randomized Controlled Trial. *Biol Psychiatry* 2007, 62: 1208-1216.

52. Poulet E, Brunelin J, et al. Repetitive transcranial magnetic stimulation does not potentiate antidepressant treatment. *Eur Psychiatry*. 2004 Sep; 19 (6): 382-3.
53. Pridmore S, Bruno R, Comparison of unlimited numbers of rapid transcranial magnetic stimulation (rTMS) and ECT treatment sessions in major depressive episode. *Int J Neuropsychopharmacol*. 2000 Jun; 3 (2): 129-134.
54. Rachid F, Bertschy G, Safety and efficacy of repetitive transcranial magnetic stimulation in the treatment of depression: a critical appraisal of the last 10 years.
55. Rosenbaum Jerrold F, MD, Judy Amy E., New Brain Stimulation Therapies for Depression. Medscape coverage of the American Psychiatric Association 2004 Annual Meeting. Accessed website www.medscape.com on February 22, 2005.
56. Rossini D, Magri L, Lucca A, et al. Does rTMS Hasten the Response to Escitalopram, Sertraline, or Venlafaxine in Patients With Major Depressive Disorder? A Double-Blind, Randomized, Sham-Controlled Trial. *J Clin Psychiatry* 66:12, December 2005.
57. Rumi DO, Gattaz WF, et al. Transcranial magnetic stimulation accelerates the antidepressant effect of amitriptyline in severe depression: a double-blind placebo-controlled study. *Biol Psychiatry*. 2005 Jan 15; 57 (2): 162-6.
58. Schulze-Rauschenbach SC, Harms U, Schlaepfer TE, Maier W, Falkai P, Wagner M, Distinctive neurocognitive effects of repetitive transcranial magnetic stimulation and electroconvulsive therapy in major depression. *Br J Psychiatry*, 2005 May; 186: 410-6.
59. Schutter DJLG. Antidepressant efficacy of high-frequency transcranial magnetic stimulation over the left dorsolateral prefrontal cortex in double-blind sham-controlled designs: a meta-analysis. *Psychological Medicine* (2009), 39, 65-75.
60. Slotema CW, Blom JD, Hock HW, Sommer IEC. Should We Expand the Toolbox of Psychiatric Treatment Methods to Include Repetitive Transcranial magnetic Stimulation (rTMS)? A Meta-Analysis of the Efficacy of rTMS in Psychiatric Disorders. *J Clin Psychiatry*, March 9, 2010 online ahead of print, (doi: 10:4088/JCP.08m04872gre).
61. Tenev V, Robinson RG, Jorge RE. Citalopram for continuation therapy following repetitive transcranial magnetic stimulation (rTMS) in vascular depression. *Am J Geriatr Psychiatry*. 2008 August; 17 (8): 682-687.
62. TMS Therapy Overview. Accessed website on November 11, 2008 www.neuronetics.com.
63. Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy. *N Engl J Med* 358:3, January 17, 2008.