Anthem BlueCross BlueShield

Behavioral Health Medical Necessity Criteria

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The Office of Medical Policy and Technological Assessment (OMPTA) has developed policies that serve as one of the sets of guidelines for coverage decisions. Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the policies. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Policy does not constitute plan authorization, nor is it an explanation of benefits.

Policies can be highly technical and complex and are provided here for informational purposes. The policies do not constitute medical or behavioral health advice or care. Treating health care providers are solely responsible for diagnosis, treatment and advice. Health plan members should discuss the information in the policies with their treating health care providers. Technology is constantly evolving and these policies are subject to change without notice. Additional policies may be developed from time to time and some may be withdrawn from use. The policies generally apply to all fully-insured benefit plans, although some local variations may exist. Additionally, some benefit plans administered by the health plans, such as some self-funded employer plans or governmental plans, may not utilize these policies. Members should contact their local customer service representative for specific coverage information.

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Introduction

This document lists our evidence-based criteria for medical necessity for the treatment of psychiatric and substance-related disorders ("behavioral health medical necessity criteria"). Behavioral Health administers mental health and substance abuse care benefits for Covered Individuals so that they can receive timely and appropriate care in a cost-effective manner and setting. Benefit coverage decisions are made while we consider both our medical necessity criteria and the information available regarding each individual case.

Please call Anthem Blue Cross and Blue Shield (hereafter referred to as 'the Plan') at 1-800-424-4014 if you require additional information.

NOTE: While the behavioral health medical necessity criteria are guidelines used by utilization review and care management staff (licensed registered nurses or licensed independent behavioral health practitioners, and physicians) to determine when services are medically necessary, federal and State law, as well as the Covered Individual's contract language, including definitions and specific contract provisions/exclusions, take precedence over the criteria, and must be considered first in determining eligibility for coverage. **For details, providers should consult the Provider Manual and Covered Individuals should consult their plan documents.**

Medical Necessity

The behavioral health medical necessity criteria have been developed for the company by an internal committee of case managers and psychiatric advisors based upon current psychiatric literature including the criteria of the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Society for Addiction Medicine, or other relevant evidence-based literature or information. On an annual basis or more frequently as needed, the behavioral health medical necessity criteria are reviewed and approved by a panel of outside practicing clinicians serving on a behavioral health subcommittee (BH Subcommittee) of The Medical Policy & Technology Assessment Committee (MPTAC), and recommendation by the BH subcommittee to change or modify the behavioral health medical necessity criteria, or establish new criteria, are reviewed and approved by MPTAC.

NOTE: PLEASE SEE THE DEFINITION OF "MEDICALLY NECESSARY" OR "MEDICAL NECESSITY" IN THE COVERED INDIVIDUAL'S PLAN DOCUMENT FOR THE PURPOSE OF MAKING BENEFIT DETERMINATIONS. THE DEFINITION BELOW MAY NOT BE THE DEFINITION OF MEDICALLY NECESSARY WITHIN THE COVERED INDIVIDUAL'S PLAN DOCUMENT. THIS DEFINTION SHOULD NOT BE USED FOR BENEFIT DETERMINATIONS FOR A COVERED INDIVIDUAL.

> "**Medically Necessary**" or "**Medical Necessity**" shall mean health care services that a medical practitioner, exercising prudent clinical judgment, would provide to a Covered Individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are **(a)** in accordance with generally accepted standards of medical practice; **(b)** clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Individual's illness, injury or disease; and **(c)** not primarily for the convenience of the Covered Individual, physician, or other health care provider; **(d)** and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Individual's illness, injury or disease. For these purposes, "generally accepted standards of medical practice"

means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician Specialty Society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

When clinical information given meets these criteria, the cases may be certified by the utilization review or care manager (licensed registered nurse or licensed independent behavioral health practitioners and physicians). When cases do not meet these criteria, cases must be sent to a psychiatrist reviewer/peer clinical reviewer for an assessment of the case. For experimental and investigational procedures and services, refer to the applicable medical policy and Covered Individual's plan document on such procedures and services.

The attached behavioral health medical necessity criteria for each level of care include three categories, Severity of Illness, Intensity of Service and Continued Stay. Severity of Illness criteria includes descriptions of the Covered Individual's condition and circumstances. Intensity of Service criteria describes the services being provided, and these criteria must be met for admission and continued stay. For continued authorization of the requested service, Continued Stay criteria must be met along with Severity of Illness criteria.

A provider who is requesting services must be afforded the opportunity for a peer-to-peer conversation regarding an adverse decision. The psychiatrist reviewer/peer clinical reviewer should use the behavioral health medical necessity criteria in reviewing a requested service for consistency, but must also use his or her discretion and professional judgment to make exceptions to the criteria when indicated by a member's unique clinical circumstances. The mental health services should not be primarily for the avoidance of incarceration of the Covered Individual or to satisfy a programmatic length of stay (refers to a pre-determine number of days or visits for a program's length instead of an individualized determination of how long a member needs to be in that program). There should be a reasonable expectation that the Covered Individual's illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the Covered Individual's illness. Custodial care is not typically a Covered Service. See Custodial Care (CG-MED-19) Clinical UM Guideline for further guidance.

These behavioral health medical necessity criteria are not meant to be exhaustive and will not cover all clinical situations. In the absence of behavioral health medical necessity criteria for a specific clinical indication, case-by-case individual review is undertaken. A psychiatrist reviewer/peer clinical reviewer designated by the company will use his/her professional judgment and take into account credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas, and other relevant factors, as they relate to the Covered Individual's clinical circumstances or characteristics of the local delivery system (such as the availability of alternative levels of care).

It is noted that there is variation in the availability of services in different geographic and regional areas. If an indicated service is not available within a Covered Individual's community at the level of service indicated by the criteria, authorization may be given for those services at the next highest available level.

In some geographical areas, state regulations allow non-physicians to treat Covered Individuals at inpatient facilities. In these behavioral health medical necessity criteria, such non-physicians with prescriptive authority who are operating within the scope of their license may be substituted where the criteria specifies a physician.

Outpatient treatment is to be provided by behavioral health providers licensed to practice independently. When individual psychotherapy, family therapy and group therapy are provided as part of a facility's inpatient, sub-acute, or intensive outpatient program, appropriate supervision of individuals who are not licensed to practice independently must be provided.

Confidentiality

Keeping a Covered Individual's medical information confidential is of the utmost importance. We take a number of measures to help insure that information is treated confidentially and privacy is respected. We request sufficient information to allow a reviewer to make an independent judgment regarding the medical necessity of a requested treatment Confidentiality of Covered Individual information is protected by federal and state law and by our corporate policy.

Diagnosis

Appropriate diagnoses are required for utilization management. Treatment approved for reimbursement by the Plan must have an appropriate diagnosis that is covered under the Covered Individual's Health Benefit Plan. Mental disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* and Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision (DSMIV-TR).**

*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

**Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision. Washington, DC, American Psychiatric Association, 2000.

Level of Care Descriptions

Acute Inpatient Hospitalization – Acute inpatient psychiatric hospitalization is defined as treatment in a hospital psychiatric unit that includes 24-hour nursing and daily active treatment under the direction of a psychiatrist and certified by The Joint Commission or the National Integrated Accreditation for Healthcare Organizations (NIAHO) as a hospital. Acute psychiatric treatment is appropriate in an inpatient setting when required to stabilize Covered Individuals who are in acute distress and return them to a level of functioning in which a lesser level of intense treatment can be provided. A need for acute inpatient care occurs when the Covered Individual requires 24-hour nursing care, close observation, assessment, treatment and a structured therapeutic environment that is available only in an acute inpatient setting.

Residential Treatment – Residential treatment is defined as specialized treatment that occurs in a residential treatment center. Licensure may differ somewhat by state, but these facilities are typically designated residential, subacute, or intermediate care facilities and may occur in care systems that provide multiple levels of care. Residential treatment is 24 hours per day and requires a minimum of one physician visit per week in a facility based setting. Wilderness programs are not considered residential treatment programs.

Partial Hospitalization – Partial hospitalization (sometimes called day treatment) is a structured, short-term treatment modality that offers nursing care and active treatment in a program that is operable at a minimum of six (6) hours per day, five (5) days per week. Covered Individuals must attend a minimum of 6 hours per day when participating in a partial hospitalization program. Covered Individuals are not cared for on a 24-hour per day basis, and typically leave the program each evening and/or weekends. Partial hospitalization treatment is provided by a multidisciplinary treatment team, which includes a psychiatrist. Partial hospitalization is an alternative to acute

inpatient hospital care and offers intensive, coordinated, multidisciplinary clinical services for Covered Individuals that are able to function in the community at a minimally appropriate level and do not present an imminent potential for harm to themselves or others.

Intensive Outpatient Treatment – Intensive outpatient is a structured, short-term treatment modality that provides a combination of individual, group and family therapy. Intensive outpatient programs meet at least three times per week, providing a minimum of three (3) hours of treatment per session. Intensive outpatient programs must be supervised by a licensed mental health professional. Intensive outpatient treatment is an alternative to inpatient or partial hospital care and offers intensive, coordinated, multidisciplinary services for Covered Individuals with an active psychiatric or substance related illness who are able to function in the community at a minimally appropriate level and present no imminent potential for harm to themselves or others.

Outpatient Treatment – Outpatient treatment is a level of care in which a mental health professional licensed to practice independently provides care to individuals in an outpatient setting, whether to the Covered Individual individually, in family therapy, or in a group modality. Traditional outpatient treatment ranges in time from medication management (e.g. 15 – 20 minutes) to 30 – 50 minutes or more for the psychotherapies.

SUBSTANCE ABUSE
INPATIENT ACUTE DETOXIFICATION

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have one of the following:

1. Nature and pattern of use of abused substance (including frequency and duration) predicts the potential for clinically significant withdrawal necessitating 24-hour medical intervention to prevent complications and that is not appropriate for a lower level of care- e.g. alcohol and benzodiazepine withdrawal (note: withdrawal from stimulants or marijuana alone generally does not require a medical detoxification and opiate detoxification is often appropriate for a lower level of care).
2. Presence of active withdrawal symptoms that can not be safely or effectively managed at a lower level of care-e.g. tremors, unstable vital signs, diaphoresis, GI disturbances, agitation, withdrawal hallucinations, confusion or disorientation or seizures.

Note: Covered Individuals who experience severe psychological withdrawal symptoms may require 24-hour care, even though they do not meet the detoxification criteria. Please refer to rehabilitation and psychiatric criteria.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify and must still meet one SI Criteria:

1. Documentation of blood and/or urine drug screen was ordered upon admission.
2. Multi-disciplinary problem-focused treatment plan which addresses psychological, social, medical, substance abuse, and aftercare needs, which is amended in a timely and appropriate manner as indicated.
3. Physician visits at least daily, seven (7) days a week.
4. 24-hour skilled nursing (by either an RN or LVN/LPN).
5. Medication management of withdrawal symptoms tailored to the Covered Individual's individual need.
6. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans with the preferred outpatient visit within one week of discharge.
7. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
8. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
9. All therapeutic services provided by licensed or certified professional in accordance with state laws.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented and the Covered Individual is not stable enough to be treated at a lower level of care.

SUBSTANCE ABUSE
INPATIENT ACUTE REHABILITATION

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Abuse and/or Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. Covered Individual no longer meets detoxification SI criteria.
2. Covered Individual has a severe co-morbid medical or psychiatric disorder, which requires 24-hour acute hospital care.
3. There is evidence of major life impairments in at least two (2) areas of functioning (work/school, family, ADL's, interpersonal).
4. The Covered Individual has expressed an interest or desire to work towards the goals of treatment and recovery, at the time of admission or shortly thereafter.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. 24-hour skilled nursing care (by either an RN or LVN/LPN).
2. Physician visits at least daily, seven (7) days a week.
3. Programming provided will be consistent with the Covered Individual's language, cognitive, speech and/or hearing abilities.
4. Implementation of individualized, problem-focused treatment plan, which includes, but is not limited to:
    a. Completion of personal substance abuse history with acknowledgement of consequences of use.
    b. Program has provisions for Covered Individual to access psychiatric treatment as needed for a dual diagnosis.
    c. Initiation or continuation of relapse/recovery program with identification of relapse triggers.
    d. Supervised attendance at community-based recovery programs when appropriate and available.
    e. Drug screens as clinically appropriate and at random.
    f. Family program and involvement in treatment, as appropriate. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.
5. Discharge planning initiated on the day of admission and includes community based recovery programs and appropriate care plans. An outpatient visit within one week of discharge is expected.
6. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
7. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
8. All therapeutic services provided by licensed or certified professional in accordance with state laws.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented, and the Covered Individual is still participating, following recommendations and continuing to show a level of motivation consistent with this intensity of treatment being potentially beneficial, but the symptoms and behaviors that required this level of care are still present to the extent that treatment on a lower level of care would not be sufficient.

SUBSTANCE ABUSE
RESIDENTIAL TREATMENT DETOXIFICATION

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Nature and pattern of use of abused substance (s) (including frequency and duration) predicts the potential for clinically significant withdrawal necessitating 24-hour medical intervention to prevent complications and is not appropriate for a lower level of care- e.g. alcohol and benzodiazepine withdrawal (note: withdrawal from stimulants or marijuana alone generally does not require a medical detoxification and opiate detoxification is generally appropriate for a lower level of care).

Presence of any of the following: may necessitate an acute hospital level of care.

a. A complicating psychiatric illness that requires inpatient treatment.
b. A withdrawal history of delirium tremens, seizures, hallucinations or acute psychotic reaction secondary to chronic alcohol use and/or polysubstance drug use.
c. An unstable medical illness that requires daily care by a consulting physician.
d. Presence of active withdrawal symptoms that cannot be safely or effectively managed at a lower level of care.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Documentation of blood and/or urine drug screen results upon admission.
2. Multi-disciplinary problem-focused treatment plan that addresses psychological, social (including living situation and support system), medical, substance abuse and rehabilitation needs which is re-evaluated and amended in a timely and medically appropriate manner as indicated..
3. Examination by a physician within 24 hours of admission and physician visits on a daily basis while in detoxification.
4. 8 hour skilled nursing (either an RN or LVN/LPN) on site with 24-hour availability. [**Note:** If the Covered Individual's medical symptoms require 24-hour nursing care for assessment, frequent administration of medication, monitoring of vital signs and other services only provided by a nurse, then acute inpatient detoxification is required].
5. Medication management of withdrawal symptoms.
6. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
7. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
8. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
9. All therapeutic services provided by licensed or certified professional in accordance with state laws.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented and the Covered Individual is not stable enough to be treated at a lower level of care.

SUBSTANCE ABUSE
RESIDENTIAL TREATMENT

Residential treatment programs are 24-hour inpatient programs but the intensity of service is much less than an inpatient rehab program.

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Abuse and/or Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must meet criteria 1 or 2 as well as 3 to qualify:

1. Acute psychiatric symptoms that would interfere with;
    a. the Covered Individual maintaining abstinence and
    b. Recovery outside of a 24 hour structured setting and
    c. Represent a deterioration from their usual status and
    d. Include either self injurious or risk taking behaviors that poses risk serious harm to the Covered Individual or others and cannot be managed outside of a 24 hour structured setting.
2. Acute medical symptoms that would likely interfere with the Covered Individual maintaining abstinence and recovery outside of a 24 hour structured setting.
3. Evidence of major functional impairment in at least 2 domains (work/school, ADL, family/interpersonal, physical health).

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Evaluation by a qualified physician within 48 hours of admission and weekly visits by a qualified physician if dually diagnosed and psychiatric symptoms identified as a reason for admission requiring this level of care.
2. Physical exam and lab tests done within 48 hours if not done prior to admission, and eight (8) hour on-site nursing (by either an RN or LVN/LPN) with 24 hour medical availability to manage medical problems if medical instability identified as a reason for admission requiring this level of care.
3. Programming provided will be consistent with the Covered Individual's language, cognitive, speech and/or hearing abilities.
4. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
5. Within 48 hours, an individualized, problem-focused treatment plan is done, based on completion of a detailed personal substance use history, including identification of consequences of use and identifying individual relapse triggers as goals.
6. The treatment would include the following at least once per day, and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy.
7. Family supports identified and contacted within 48 hours and family/primary support person participation in treatment at least weekly unless contraindicated. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.
8. Discharge planning completed within one (1) week of admission including identification of community/family resources, sober supports, connection or re-establishment of connection to community based recovery programs and professional aftercare treatment.
9. Drug screens used after all off-grounds activities and whenever otherwise indicated.
10. All therapeutic services provided by licensed or certified professionals in accordance with state laws.
11. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their rehabilitation in a community setting.
12. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
13. All therapeutic services provided by licensed or certified professional in accordance with state laws.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward all goals in the treatment plan must be documented in weekly treatment plan reviews. If progress is not being achieved, then the treatment plan must be revised with achievable treatment goals.
2. The Covered Individual is still participating, following recommendations and continuing to show a level of motivation such that treatment goals can be achieved.

SUBSTANCE ABUSE
SUBSTANCE ABUSE PARTIAL HOSPITALIZATION PROGRAM (PHP)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Abuse and/or Dependence diagnosis. Co-morbid psychiatric conditions frequently occur and should be assessed upon admission. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. Symptoms or behaviors that could be treated must be present that would likely progress to a level of dangerousness or failure of self care that would require inpatient treatment without a structured treatment setting of at least six (6) hours duration a day.
2. Significant functional impairment as evidenced by inability to work or attend school, impaired self care and significant conflicts with the support environment.
3. The Covered Individual does not also meet criteria for IOP.
4. PHP could help stabilize the social environment to an extent that would allow continued treatment of Covered Individual at a lower level of care.
5. The Covered Individual has demonstrated a level of motivation that is consistent with PHP level treatment being of potential benefit; if the primary purpose of PHP is for motivational enhancement, then there must be evidence of psychiatric or medical risks that are too high for treatment at a lower level of care.

INTENSITY OF SERVICE (IS)

Must have all the following to qualify:

1. The service is provided for 6-8 hours a day at least five (5) days a week.
2. Nursing and MD treatment is documented if needed as evidenced by acute medical or psychiatric interventions being listed on the treatment plan.
3. Programming provided is consistent with the Covered Individual's language, cognitive, speech and/or hearing abilities.
4. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
5. An individualized treatment plan is implemented with anticipated dates of completion that are tied to the Covered Individual's needs, not a fixed program schedule, and includes:
    a. Completion of a personal substance abuse history with acknowledgement of consequences of use.
    b. Initiation or continuation of relapse/recovery program with identification of relapse triggers.
    c. Goal of attendance at community-based recovery programs-to be attended at least two (2) times per week or documented rationale as to why this should not be required.
    d. Drug screens are obtained on a random basis with evidence of an adjustment to the treatment plan if results are positive.
    e. Family involvement in treatment as appropriate. For adolescents this should include individual family sessions at least one time each week, unless clinically contraindicated.
6. If a behavioral health diagnosis is present requiring active treatment or the facility is providing dual diagnosis services, qualified physician visits are documented as necessary.
7. All therapeutic services are provided by licensed or certified professionals in accordance with state requirements.
8. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their rehabilitation in a community setting.
9. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
10. The Covered Individual resides in a community setting while receiving partial hospitalization services and is not in a 24-hour

residential treatment setting.

11. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

SUBSTANCE ABUSE
INTENSIVE STRUCTURED OUTPATIENT PROGRAM (IOP)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Abuse and/or Dependence diagnosis. Co-morbid psychiatric conditions frequently occur and should be assessed upon admission. All services must meet the definition of medical necessity in the Covered Individual's plan document.

IOP level of care may be appropriate for the first attempt at rehabilitation. The structure and educational benefits of this level of care compared to individual outpatient may lead to better outcomes for certain Covered Individuals.

Must meet all of the following to qualify:

1. The pattern of substance use and behavior is unlikely to change with outpatient treatment and community resources alone. However, the Covered Individual is able to live safely in the community with adequate functioning.
2. There is evidence that the Covered Individual is motivated, as evidenced by an expression of an interest or desire to work towards the goals of treatment and recovery at the time of admission or shortly thereafter.
3. The patient's social system and significant others are supportive of recovery, and the Covered Individual demonstrates the motivation, social and cognitive skills to develop a sober support system.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Meets a minimum of three (3) days per week at least three (3) hours per day; the frequency may be decreased as clinically indicated.
2. Programming provided will be consistent with the Covered Individual's language, cognitive, speech and/or hearing abilities.
3. Implementation of individualized, problem-focused treatment plan which includes, but is not limited to:
    a. Completion of personal substance abuse history with acknowledgment of consequences of use.
    b. Initiation or continuation of relapse/recovery program with identification of relapse triggers.
    c. Attendance at community-based recovery programs - to be attended at least three (3) times per week.
    d. Drug screens as clinically appropriate and at random and an intervention plan to address drug use while in treatment.
    e. Family program and involvement in treatment as appropriate. For adolescents, at least one time each week, unless clinically contraindicated.
    f. The program has provisions for Covered Individual to access psychiatric treatment for a dual diagnosis, as needed.
4. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
5. All therapeutic services are provided by licensed or certified professionals in accordance with state requirements.
6. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
7. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their rehabilitation in a community setting.
8. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.
9. The Covered Individual resides in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to

treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

SUBSTANCE ABUSE
OUTPATIENT TREATMENT

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM or ICD-9 Axis I Substance Abuse and/or Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. Substance use is excessive, maladaptive and some symptoms have persisted for at least one (1) month or have occurred as part of a repeated pattern over a longer period of time.
2. There is evidence that the Covered Individual is motivated as evidenced by expression of an interest or desire to work towards the goals of treatment recovery or can be motivated.
3. Covered Individual's social system and significant others are supportive of recovery, or Covered Individual demonstrates the social and cognitive skills to develop a sober support system.
4. Covered Individual does not meet the criteria for a higher level of care.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Frequency:
    a. Initial: Up to a maximum of six (6) therapy sessions within the first three (3) week period. For adolescents, this should also include one (1) family session per week.
    b. Ongoing: Short term problem focused therapy in conjunction with community based programs and frequency of visits should be decreased over time to generally less than one time per week.
2. Documentation of complete drug and alcohol assessment.
3. Assessment of family and social support system.
4. Individual treatment plan which includes:
    a. Identification of recovery goals.
    b. Issues such as mental preoccupation with alcohol or drug use, cravings, peer pressure, lifestyle, consequences of use, and attitudinal changes are addressed.
    c. Development of a relapse prevention plan and sober support system.
    d. Monitoring attendance at community-based recovery programs.
    e. Utilization of educational materials (books, videos).
    f. Drug screens as clinically appropriate (may require coordination with a physician).
    g. Development of a discharge/aftercare plan.
    h. Referred to psychiatric services for a dual diagnosis, as needed.
5. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
6. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

SUBSTANCE ABUSE OUTPATIENT DETOXIFICATION WITHOUT EXTENDED ON-SITE MONITORING (OFFICE BASED)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must meet either 1 or 2, and also meet 3 and 4:

1. Nature and pattern of use of abused substance requires gradual, medically supervised outpatient withdrawal to prevent complications, and the severity of anticipated withdrawal does not require a structured treatment setting (Withdrawal from amphetamine/cocaine and marijuana, unless accompanied by psychosis, do not generally require a medical detoxification) or,
2. Presence of mild to moderate withdrawal symptoms that can be managed outside of a structured treatment setting, meeting one of the following:
    a. For alcohol, mild withdrawal symptoms (as evidenced by a CIWA-Ar score of 8 or less or the equivalent on a comparable standardized scoring system).
    b. For sedative-hypnotics:
        i. Any recent use is confined to therapeutic or near-therapeutic dosages AND
        ii. Sedative hypnotic use is not complicated by daily use of alcohol or other drugs known to produce a significant withdrawal syndrome.
    c. For opioids without using opioid substitution methods of detoxification (Must meet either i or ii, **and** also meet iii):
        i. Either the Covered Individual's use of high-potency opioids (such as injectable or smoked forms) has not been daily for more than two (2) weeks prior to initiation of treatment, or the use of high-potency opioids is at or near the therapeutically recommended level, OR
        ii. There has been no repetitive use in the past two (2) weeks of injectable or smoked forms of opioids, AND
        iii. Absence of significantly unstable vital signs or severe withdrawal symptoms that meet criteria for a higher level of care.
    d. For opioids with use of opioid substitution methods of detoxification:
        i. Absence of significantly unstable vital signs or severe withdrawal symptoms that meet criteria for a higher level of care.
    e. For stimulants, the Covered Individual is withdrawing from stimulants and is experiencing significant lethargy, agitation, paranoia, mild psychotic symptoms or moderate depression, but has good impulse control.
3. Must meet all of the following to qualify. Failure to meet these would suggest that a higher level of care such as sub-acute/ residential or acute inpatient detoxification is required:
    a. Absence of a complicating psychiatric illness that requires inpatient or residential treatment.
    b. Absence of a withdrawal history of delirium tremens, seizures, hallucinations or acute psychotic reaction secondary to chronic substance use.
    c. Absence of an unstable medical illness that requires 24-hour medically-supervised monitoring during withdrawal.
    d. Withdrawal from sedative-hypnotics is not generally of concern but may be problematic if there is concurrent use of stimulants.
    e. Severe withdrawal symptoms between visits are assessed to be unlikely.
4. The Covered Individual is assessed as likely to complete needed detoxification and to enter into continued treatment or self-help recovery, including the Covered Individual's expression of an interest or desire to work towards the goals of treatment and recovery (or, for children and adolescents, a family support system likely to ensure continued treatment).

SUBSTANCE ABUSE OUTPATIENT DETOXIFICATION WITHOUT EXTENDED ON-SITE MONITORING (OFFICE BASED)

(CONTINUED)

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Detoxification takes place in a health care facility such as a physician's office, hospital outpatient department, mental health treatment facility or addiction treatment facility.
2. The withdrawal is managed by a physician, who assesses the Covered Individual each day that detoxification services are provided, and who provides for 24-hour emergency coverage during detoxification.
    a. In cases of opioid substitution methods of detoxification, the withdrawal is managed by a physician authorized by the DEA to use opioids for detoxification.
3. The physician has the training and skills to conduct psychosocial substance abuse rehabilitation treatment, or has ready access other licensed or certified professionals who have such qualifications.
4. A comprehensive medical history and physical examination by a physician upon initiation of treatment.
5. An addiction-focused history obtained as part of the initial assessment and reviewed by the physician during the admission process.
6. Appropriate laboratory and toxicology tests are performed.
7. Problem-focused treatment plan that addresses psychological, social (including living situation and support system), medical, substance abuse and rehabilitation needs.
8. Daily assessment of progress during detoxification and any treatment changes (or less frequent if the severity of withdrawal is documented to be sufficiently mild or stable).
9. Discharge/aftercare planning is initiated on the day of admission and includes appropriate continuing care plans and referral arrangements as needed.
10. Coordination of care with other clinicians providing care to the Covered Individual or family members, including psychiatrist/therapist and PCP is documented.
11. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

SUBSTANCE ABUSE OUTPATIENT DETOXIFICATION WITH EXTENDED ON-SITE MONITORING

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual's symptoms or condition must meet the diagnostic criteria for a DSM Axis I or ICD-9 Substance Dependence diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must meet either 1 or 2, and also meet 3 and 4:

1. Nature and pattern of use of abused substance requires gradual, medically supervised outpatient withdrawal to prevent complications that cannot be managed outside of a structured treatment setting, but do not require 24-hour medical monitoring. (Withdrawal from amphetamine/cocaine and marijuana, unless accompanied by psychosis, do not generally require a medical detoxification) or,
2. Presence of moderate withdrawal symptoms that cannot be managed outside of a daily structured treatment setting; but do not require 24-hour medical monitoring. Adequate arrangements can be made for treatment of withdrawal symptoms during the times that the program does not meet.
    a. For alcohol, opioids and sedative-hypnotics:
        i. The Covered Individual is experiencing signs and symptoms of withdrawal such as abnormal vital signs, and evidence of physical discomfort or cravings that make it unlikely that the Covered Individual would be able to abstain long enough to withdraw without a structured treatment setting.
        ii. Withdrawal symptoms have responded to, or are likely to respond to, normal therapeutic doses of benzodiazepines, opiates or sedative-hypnotics in the therapeutic range AND
        iii. The risk of seizures, hallucinations, dissociation or severe affective disturbances during unobserved periods is assessed to be minimal.
        iv. The abstinence syndrome can be stabilized at the end of each day's monitoring so that the Covered Individual can manage such symptoms at home with appropriate supervision.
    b. For stimulants, the Covered Individual who is withdrawing from stimulants and is experiencing significant lethargy, agitation, paranoia, stimulant-induced psychotic symptoms or severe depression, and requires extended outpatient monitoring to assess impulse control and readiness for substance abuse rehab treatment or the need for psychiatric hospitalization to address psychotic symptoms. (NOTE: This assessment and referral to another level of care should be completed within one treatment day).
3. *Must meet all of the following to qualify.* Failure to meet these would suggest that a higher level of care such as sub-acute/ residential or acute inpatient detoxification is required*:*
    a. Absence of a complicating psychiatric illness that requires inpatient or residential treatment.
    b. Absence of a withdrawal history of delirium tremens, seizures, hallucinations or acute psychotic reaction secondary to chronic substance use.
    c. Absence of an unstable medical illness that requires 24-hour medically-supervised monitoring during withdrawal.
    d. If the sedative-hypnotic withdrawal is being treated, there is no comorbid substance withdrawal from alcohol, opiates or stimulants.
    e. Severe withdrawal symptoms outside normal program hours are assessed to be unlikely.
4. A well-defined clinical rationale is documented that explains why Covered Individual would not be a reasonable candidate for office-based outpatient management of withdrawal symptoms, along with community supports.

SUBSTANCE ABUSE OUTPATIENT DETOXIFICATION WITH EXTENDED ON-SITE MONITORING

(CONTINUED)

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Detoxification is conducted in a medical facility (i.e. hospital or medical clinic) to determine the need for more or less intensive detoxification services. The detoxification is conducted in a facility that is fully integrated with intensive outpatient or partial hospital substance abuse rehabilitation services.
2. Documentation of blood and/or urine drug screen results upon admission and as clinically indicated.
3. Multi-disciplinary problem-focused treatment plan that addresses psychological, social (including living situation and support system), medical, substance abuse and rehabilitation needs.
4. Examination by a physician, (or physician extender or independently licensed clinician as allowed by law or health plan benefits), upon admission and ready availability of a physician for consultation on a daily basis while in detoxification.
5. An addiction-focused history obtained as part of the initial assessment and reviewed by the physician during the admission process.
6. At least 3 hour skilled nursing (either an RN or LVN) on site with availability during all hours of program operation. [**Note** If the Covered Individual's medical symptoms require 24-hour nursing care for assessment, frequent administration of medication, monitoring of vital signs and other services only provided by a nurse, then acute inpatient detoxification is required].
7. Medication management of withdrawal symptoms, with all controlled substances used for detoxification administered by persons appropriately licensed to dispense controlled substances.
8. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
9. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
10. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress toward treatment goals is being documented, as shown by continued participation, abstinence, and adherence to treatment recommendations, and if no progress noted or relapse occurs, the treatment plan is re-evaluated and amended such that progress will be likely.

SUBSTANCE ABUSE
OUTPATIENT (OFFICE BASED) MEDICATION ASSISTED TREATMENT (MAT) OF OPIOID DEPENDENCE

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: To qualify, Covered Individual must meet the diagnostic criteria for a DSM diagnosis of Opioid Dependence

Must have all of the following to qualify:

1. There is a reasonable expectation of compliance.
2. There is evidence that the Covered Individual has restorative potential. This will be demonstrated in part, although not limited to, Covered Individual's expression of an interest or desire to work towards the goals of treatment and recovery, including abstinence from all illicit substance use and all opioid use.
3. Covered Individual's social system and significant others are supportive of recovery, or Covered Individual demonstrates the social and cognitive skills to develop a sober support system.
4. There is documentation of the absence of current, active untreated use of alcohol, sedative-hypnotics or other central nervous system depressants.
5. If the Covered Individual is pregnant, the obstetrician or other provider managing the pregnancy has been consulted and concurs with the treatment plan before MAT is initiated.
6. The Covered Individual is not acutely psychotic, imminently suicidal, or imminently homicidal.
7. The Covered Individual gives permission for free exchange of clinical information among all health care providers, including pharmacists.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Treatment conforms to the requirements of The Drug Addiction Treatment Act of 2000 (DATA 2000) and all related Federal and State regulations.
    a. MAT is managed by a physician who has been granted a *waiver* from the special registration requirements in the Controlled Substances Act to provide opioid addiction therapy with approved Schedule III, IV, or V narcotics.
    b. Only approved Schedule III, IV, or V narcotics are utilized; no Schedule II narcotics are utilized.
2. The physician assesses the Covered Individual face-to-face on each day that MAT services are provided, and provides for 24-hour emergency coverage during MAT.
3. Face-to-face assessment at least monthly by the prescribing physician.
4. Psychiatric consultation is completed within the first 30 days for any Covered Individual with a DSM diagnosis which may interfere with recovery.
5. Coordination of care among all prescribing providers.
6. Coordination of care with mental health and substance abuse recovery providers occurs in a timely manner.
7. Assessment of family and social support system occurs within the first week of treatment.
8. Individual treatment plan which includes:
    a. Psychosocial components of treatment by licensed or certified substance abuse and/or behavioral health providers at intervals appropriate to the stage of recovery. The psychosocial component of treatment may also be provided by a physician who has the appropriate training and experience to provide such treatment.
    b. Management of impediments to recovery including interpersonal, legal, financial and housing.
    c. Tapering of MAT in a manner that is medically appropriate for discontinuation of all opioids (unless treatment is for maintenance).
    d. Monitoring attendance at community-based recovery programs.
    e. Utilization of educational materials (books, videos).
    f. Monitoring of adherence using drug screening, pill counts or both.
    g. Development of a discharge/aftercare plan.

h. Referral to psychiatric services for a dual diagnosis, as needed.

9. Evaluation for medication that may improve the member's ability to remain abstinent; document the rationale if no medication is prescribed.

B. CONTINUED STAY CRITERIA (CS)

NOTE: Relapse is considered an integral part of the disease concept and does not singularly constitute treatment failure or need for a higher level of care.

Must continue to meet "SI/IS" Criteria and have all of the following to qualify:

1. Progress toward treatment goals is being documented (see "IS").
2. Treatment plan is being re-evaluated and amended in a timely and medically appropriate manner.
3. Covered Individual continues to regularly attend community-based recovery programs until sustained abstinence is demonstrated.
4. Covered Individual continues to show motivation for abstinence and recovery, is accepting responsibility, and is gaining insight.
5. Covered Individual is maintaining sobriety or showing progress toward maintaining sobriety for the first 6 months of MAT.
6. Covered Individual is maintaining sobriety after the first 6 months of MAT.

PSYCHIATRIC
ACUTE INPATIENT

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD 9 Diagnosis that is consistent with symptoms and the primary focus of treatment is psychiatric care. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have one (1) of the following to qualify:

1. **Imminent suicidal risk or danger to others** - immediate danger to self and/or others is apparent or behavior indicating a plan that would result in risk to self or others, such that the degree of intent, method, and immediacy of the plan requires a restrictive inpatient setting with psychiatric medical management and nursing interventions on a 24-hour basis.
2. **Presence of acute psychotic symptoms** – severe clinical manifestations, symptoms or complications that creates immediate risk to self or others due to impairment in judgment which preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and require 24-hour nursing/medical assessment, intervention and/or monitoring.
3. **Grave disability** - acute impairment exists, as evidenced by severe and rapid decrease in level of functioning in several areas of life (work, family, ADL's, interpersonal), to the degree that the Covered Individual is unable to care for him or herself, and therefore an imminent danger to themselves or others which preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and require 24-hour nursing/medical assessment, intervention and/or monitoring.
4. **Self-injury or uncontrolled risk taking behaviors** or uncontrollable destructive behavior creating immediate risk to self or others which requires medical intervention and containment in a 24-hour a day acute setting.

INTENSITY OF SERVICE / TREATMENT COMPONENTS (IS)

Must have all of the following components to qualify for Acute Inpatient:

1. Multi-disciplinary assessment with a treatment plan which addresses psychological, social, medical, and substance abuse needs.
2. Documentation of blood and/or urine drug screen results upon admission and as appropriate.
3. Attending Physician visits at least daily, seven (7) days a week.
4. Medication evaluation and documented rationale if no medication is prescribed.
5. Family assessment and therapy when appropriate. For children and adolescents, a minimum of one (1) to two (2) times per week with an initial family session expected to occur within the first 72 hours of admission, unless clinically contraindicated.
6. Suicide/homicide precautions as required.
7. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
8. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is documented. If progress (clinical improvement) is not occurring, the treatment plan is being re-evaluated and amended in a timely and medically appropriate manner.
2. The treatment being delivered is likely to stabilize the symptoms/behaviors that required admission.
3. If voluntary, the Covered Individual is cooperating with treatment; if the Covered Individual is involuntary and not cooperating with treatment, the provider has acted in a timely fashion to get legal permission to treat the symptoms/behaviors that required admission.
4. There is a reasonable expectation that the Covered Individual's illness, condition or level of functioning that required admission is likely to stabilize so that that treatment can be continued at a lower level of care. Custodial care is not typically

a Covered Service,

PSYCHIATRIC SUBACUTE
RESIDENTIAL TREATMENT CENTER (RTC)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Diagnosis that is consistent with symptoms and the primary focus of treatment is psychiatric care. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. The Covered Individual is manifesting symptoms and behaviors which represent a deterioration from their usual status and include either self injurious or risk taking behaviors that risk serious harm and cannot be managed outside of a 24 hour structured setting.
2. The social environment is characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while the Covered Individual is in the residential facility.
3. There should be a reasonable expectation that the illness, condition or level of functioning will be stabilized and improved and that a short term, subacute residential treatment service will have a likely benefit on the behaviors/symptoms that required this level of care, and that the Covered Individual will be able to return to outpatient treatment.
4.

INTENSITY OF SERVICE (IS)

Must have all the following to qualify:

1. Residential treatment takes place in a structured facility-based setting. Wilderness programs are not considered residential treatment.
2. Documentation shows that a blood or urine drug screen was done on admission and during treatment if indicated.
3. Evaluation by a qualified physician done within 48 hours, and physical exam and lab tests unless done prior to admission, and eight (8) hour on-site nursing (by either an RN or LVN/LPN) with 24 hour medical availability to manage medical problems if medical instability identified as a reason for admission to this level of care.
4. Within 72 hours, a multidisciplinary assessment with an individualized problem-focused treatment plan completed, addressing psychiatric, academic, social, medical, family and substance use needs.
5. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
6. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.
7. Skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with 24 hour availability.
8. Individual treatment with a qualified physician at least once a week including medication management if indicated.
9. Individual treatment with a licensed behavioral health clinician at least once a week.
10. Unless contraindicated, family members participate in development of the treatment plan, participate in family program and groups and receive family therapy at least once a week, including in-person family therapy at least once a month if the provider is not geographically accessible. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.
11. A discharge plan is completed within one week that includes who the outpatient providers will be and where the Covered Individual will reside.
12. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their treatment in a community setting.
13. Medication evaluation and documented rationale if no medication is prescribed.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

SI criteria are still met and likelihood of benefit and return to OP treatment is shown by adherence to the treatment plan and recommendations by the Covered Individual and by progress in treatment; if progress is not occurring than the treatment plan is

being amended in a timely and medically appropriate manner with treatment goals still achievable.

PSYCHIATRIC
PARTIAL HOSPITALIZATION PROGRAM (PHP)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Diagnosis that is consistent with symptoms and the primary focus of treatment is psychiatric care. All services must meet the definition of medical necessity in the covered individual's plan document.

Must have 1-4 or 1-5 if coming directly from a higher level of care to qualify:

1. Symptoms or behaviors that could be treated must be present that would likely progress to a level of dangerousness or failure of self care that would require Inpatient treatment without a structured treatment setting of at least six (6) hours duration a day.
2. Significant functional impairment is present as evidenced by inability to work or attend school, impaired self care and significant conflicts with the support environment.
3. The Covered Individual does not also meet criteria for IOP.
4. The Covered Individual's social environment may not be supportive but is adequate for the individual to cope and PHP could help stabilize the social environment to an extent that would allow continued treatment at a lower level of care.
5. Covered Individual has been discharged from a higher level of care and continues to require an intensive, structured treatment program to maintain progress and stability during a period of transition to a lower level of care.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Provide multidisciplinary program of therapeutic services for six (6) to eight (8) hours a day at least five (5) times a week. Normally, the goals of treatment or maximum treatment benefit at this level of care can be achieved within ten (10) days of partial hospitalization program treatment.
2. Multidisciplinary assessment with a treatment plan which addresses psychological, social, medical, and substance abuse needs.
3. Evaluation by a qualified physician done by the second day of attendance and at least weekly visits thereafter.
4. Monitoring of psychotropic medications including compliance as appropriate and documented rationale if no medication is prescribed.
5. Family assessment and therapy by a licensed behavioral health provider when appropriate. For children and adolescents, at least one (1) to two (2) times each week, unless clinically contraindicated.
6. Individual therapy by a licensed provider at least weekly.
7. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
8. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
9. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their treatment in a community setting.
10. The Covered Individual resides in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting.
11. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented and the Covered Individual's participation and cooperation with treatment is consistent with PHP having continued benefit; if no progress then the treatment plan is being re-evaluated and amended in a timely and medically appropriate manner that is likely to be of benefit.

PSYCHIATRIC
INTENSIVE STRUCTURED OUTPATIENT PROGRAM (IOP)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Diagnosis that is consistent with symptoms and the primary focus of treatment is psychiatric care. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must meet either 1 or 2, and 3 to qualify:

1. Serious symptoms or serious impairment in social, occupational or family functioning that requires intensive and structured intervention.
2. A well-defined clinical rationale is documented that explains why Covered Individual would not be a reasonable candidate for outpatient therapy combined with community supports.
3. The Covered Individual has adequate cognitive abilities, to assume responsibility for behavioral change, and is capable of developing skills to cope with their symptoms.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Provide multidisciplinary program of at least three (3) treatment hours per day at least three times per week; the frequency may be decreased as clinically indicated.
2. Multidisciplinary assessment with an individualized treatment plan which addresses psychological, social, medical, cognitive, and substance abuse needs. This should include coordination of care with Covered Individual's outpatient providers.
3. To be seen by a qualified physician by the third day of attendance (unless stepping down from a higher level of care).
4. Monitoring of psychotropic medications including compliance as appropriate and documented rationale if no medication is prescribed. Medication management external to program is reflected in program documentation.
5. Family assessment and therapy by a licensed behavioral health provider. For children and adolescents, at least one time each week, unless clinically contraindicated.
6. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
7. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
8. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their treatment in a community setting.
9. The Covered Individual resides in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress in treatment is being documented and the Covered Individual's participation and cooperation with treatment is consistent with IOP having continued benefit; if no progress then the treatment plan is being re-evaluated and amended in a timely and medically appropriate manner that is likely to be of benefit.

INPATIENT/OUTPATIENT ECT

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current Axis I Diagnosis of Major Depression, Bipolar Disorder, Mood Disorder, Severe Parkinson's Disease, Organic Catatonia, Schizoaffective Disorder or Schizophrenia and symptoms to confirm the diagnosis. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must meet criteria 1 and either 2 or 3.

1. Must have one of the following:
    a. History of a poor response to several trials of antidepressants in adequate doses for a sufficient time.
    b. History of a good response to ECT during an earlier episode of illness.
    c. Need for a rapid response due to the potentially life threatening nature of the Covered Individual's illness.
    d. Adverse effects with medication which are deemed to be less likely and/or severe with ECT.
2. For outpatient ECT, Covered Individual must have adequate social and environmental support to maintain effective and safe treatment on an outpatient basis.
3. For inpatient ECT, Covered Individual must meet Severity of Illness (SI) Criteria for psychiatric adult/adolescent/child inpatient.

INTENSITY OF SERVICE (IS)

1. History and physical completed within the 30 days prior to treatment and updated as needed.
2. The qualified physician performing the ECT procedure must do a procedure note for each ECT treatment.
3. The qualified physician performing the ECT and the Covered Individual's attending physician must confer regularly regarding the Covered Individual's progress.
4. Discharge planning is initiated on the day of admission and includes appropriate continuing care plans.
5. The number and frequency of treatments requested are appropriate to the Covered Individual's clinical condition and response.
6. For ECT being done in an inpatient setting, Intensity of Service (IS) Criteria must be met for Adult Psychiatric Inpatient or outpatient ECT not available.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress after the expected minimum number of treatments usually needed (based on the diagnosis) is being documented and maximal benefit has not yet been achieved.

EATING DISORDER
ACUTE INPATIENT

(Co-morbid disorders may influence choice of Level of Care)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Eating Disorder Diagnosis that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have one of 1-3 and both 4 and 5 to qualify:

1. Medical Complications attributable to the eating disorder, which typically include the following:
    a. Vital Sign abnormalities: For adults, pulse rate <40, orthostatic pulse change >20, blood pressure <90/60, orthostatic bp change >10-20, temp <96-97 F. For children/adolescents, pulse rate <50 daytime, 45 nighttime, orthostatic pulse change >20, blood pressure <80/50, orthostatic bp change >10-20 and temp <96-97 F.
    b. Electrolyte abnormalities, including hypokalemia or hypophosphatemia.
    c. Cardiac compromise, including dysrhythmias or prolonged QTc.
    d. Organ damage requiring treatment, including renal, hepatic, GI or cardiovascular.
    e. Acute dehydration as shown by physical and lab findings requiring medical rehydration.
2. For Anorexia Nervosa, BMI <15 or < 75% of individually estimated ideal body weight range, or, rapid weight loss combined with active refusal to eat on a trajectory showing that this BMI or weight will occur within a few days.

   For Bulimia Nervosa or Eating Disorder NOS medical abnormalities (see SI 1) must be demonstrated and can be safely treated in a psychiatric unit and do not require intensity of a medical unit.
3. Severe eating disorder comorbid with psychiatric symptoms that would in themselves require inpatient treatment, such as suicidal ideation with intent or a feasible plan or other conditions that would meet Inpatient Psychiatric Severity of Illness criteria (if other Eating Disorder Inpatient criteria not met, Inpatient Psychiatric service should be used).
4. Worsening symptoms and behaviors despite current treatment in a structured outpatient ED service (IOP or PHP, or 2-3 times a week OP treatment involving an ED BH clinician, nutritionist and a qualified physician where intensive services not geographically available) with the likelihood that Inpatient treatment will result in improvement– this criterion not necessary if the Covered Individual is actively resistant to treatment, actively uncooperative and/or has severely impaired insight and does not recognize any need for treatment.
5. Supervision required during and after all meals and in the evening to prevent restricting or excessive exercising/purging behaviors; for children/adolescents, family not able to supervise due to severe conflict or treatment resistance.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Multidisciplinary assessment with a treatment plan which addresses nutritional, psychological, social, medical, and substance abuse needs.
2. Relevant medical tests including lab tests (electrolytes, chemistry, CBC, thyroid) and ECG done on admission and follow up tests done if any abnormality requiring intervention.
3. Documentation of treatment by a qualified physician seven (7) days a week, including management of psychiatric medication if indicated, or documentation as to why not used if indicated.
4. Individual therapy by a licensed provider at least once per week, family therapy by a licensed provider at least once per week for adults and twice per week for children/adolescents (unless contraindicated, with documentation for the reason).
5. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
6. Nutritional plan with target weight range and refeeding plan to achieve gain of 1-2 pounds per week (if low body weight

reason for admission).

7. 24-hour skilled nursing (by either an RN or LVN/LPN).
8. Discharge plan with recommended aftercare including coordination with outpatient treatment team or development of an outpatient treatment plan if not already present.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have 1 or 2 and 3-5 to qualify:

1. Progress in treatment is documented including: weight gain, increasing adherence with meal plan, medical stabilization, stabilization of acute psychiatric symptoms, cooperation with discharge planning; for treatment of low body weight with medical instability complicated by need for involuntary treatment, very poor insight and motivation or active treatment resistance and poor family/social support, level of weight gain may need to surpass admission criteria and reach a level that is consistent with medical and physical indications of malnutrition having stabilized and weight/BMI in low normal range.
2. Lack of progress or persistent symptoms/behaviors have resulted in changes to the treatment plan to address treatment resistance that has a likelihood of achieving progress.
3. The Covered Individual is cooperative and responsive to treatment or treatment team has taken steps to treat involuntarily including petition for medical conservatorship, medication hearing or involuntary hospitalization.
4. For children/adolescents or dependant adults, family is actively involved in treatment and responsive to treatment recommendations.
5. For Covered Individuals with chronic, persistent Eating Disorders where normal weight range or absence of binge/purge or non-purge bulimic symptoms has not been present for over one (1) year, the Covered Individual is not at a level of control and stability consistent with their usual/baseline condition.

EATING DISORDER
RESIDENTIAL TREATMENT CENTER (RTC)

(Co-morbid disorders may influence choice of Level of Care)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Eating Disorder Diagnosis that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. If Anorexia Nervosa and weight restoration is goal, BMI between 15-18 or weight between 75%-85% of estimated ideal weight range and no signs or symptoms of acute medical instability that would require daily physician evaluation.
2. Comorbid psychiatric disorders are controlled or stable enough for the primary focus of treatment to be the eating disorder.
3. For Anorexia Nervosa, continued restricting and purging is leading to weight loss that is likely to lead to medical instability and need for inpatient treatment with the likelihood that residential treatment will result in improvement; for Bulimia Nervosa, continued purging or excessive exercising is likely to cause medical instability or dehydration that would need inpatient treatment; or for either condition, the Covered Individual has had multiple inpatient admissions within the past six (6) months with a failure to stabilize with outpatient aftercare.
4. Significant functional disruption from usual/baseline status in at least two domains (school/work, family, activities, ADL's) related to the eating disorder.
5. Based on past treatment history, usual level of functioning and comorbid psychiatric disorders, there is a reasonable expectation that the Covered Individual will benefit from this level of care.
6. Living environment and support are characterized by either significant deficits or significant conflict or problems that would undermine goals of treatment such that treatment at a lower level of care is unlikely to be successful, and this can potentially be improved with treatment.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Evaluation by a qualified physician or equivalent professional within 72 hours of admission and at least once weekly visits documented.
2. Physical exam and lab tests done within 72 hours if not done prior to admission, and 24 hour on site nursing and medical availability to manage medical problems if risk for medical instability identified as a reason for admission to this level of care.
3. Programming provided will be consistent with the Covered Individual's language, cognitive, speech and/or hearing abilities.
4. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
5. Within seven (7) days, an individualized problem focused treatment plan completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex bio-psychosocial evaluation, and this needs to be reviewed at least once a week for progress.
6. Treatment would include the following at least once per day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy plus at least once weekly individual therapy with a properly licensed provider.
7. Family supports identified and contacted within 72 hours and family/primary support person participation at least weekly for adults, twice weekly for children and adolescents, unless contraindicated.
8. Discharge planning initiated within one (1) week of admission including identification of community/family resources, connection or re-establishment of connection to an outpatient treatment team and coordination with that team.
9. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered

Individuals will be prepared to receive the majority of their treatment in a community setting.

10. Medication evaluation and documented rationale if no medication is prescribed.

EATING DISORDER
RESIDENTIAL TREATMENT CENTER (RTC)

(CONTINUED)

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. If low bodyweight a reason for admission, target weight for safe treatment on an outpatient basis listed and weight gain of 1-2 pounds per week documented.
2. Progress toward treatment goals is documented as shown by motivation on the part of the Covered Individual and family, adherence to treatment recommendations including weight gain and acceptance of recommended dietary caloric intake if low body weight was a reason for admission and control of binging and purging or non-purging bulimic symptoms, but treatment goals that would allow continued treatment at a lower level of care have not been achieved; if progress not achieved than the treatment plan has been adjusted in a manner that is likely to achieve progress toward meeting treatment goals or treatment goals have been adjusted.

EATING DISORDER
RESIDENTIAL TREATMENT CENTER (RTC) WITHOUT 24-HOUR NURSING

(Co-morbid disorders may influence choice of Level of Care)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Eating Disorder Diagnosis that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. If Anorexia Nervosa and weight restoration is goal, BMI between 15-18 or weight between 75%-85% of estimated ideal weight range and no signs or symptoms of acute medical instability that would require daily physician evaluation, and no cardiovascular or metabolic impairment that would require daily nursing monitoring, including vital signs and frequent lab tests.
2. Comorbid psychiatric disorders are controlled or stable enough for the primary focus of treatment to be the eating disorder.
3. For Anorexia Nervosa, continued restricting and purging is leading to weight loss that is likely to lead to medical instability and need for Inpatient treatment despite receiving structured outpatient ED treatment (IOP or PHP, or 2-3 times a week OP treatment involving an ED BH clinician, nutritionist and a qualified physician where intensive services not geographically available) with the likelihood that residential treatment will result in improvement; for Bulimia Nervosa, continued purging or excessive exercising is likely to cause medical instability or dehydration that would need inpatient treatment despite receiving the same level of outpatient treatment described above; or for either condition, the Covered Individual has had multiple inpatient admissions within the past six (6) months with a failure to stabilize with outpatient aftercare.
4. Significant functional disruption from usual/baseline status in at least two domains (school/work, family, activities, ADL's) related to the eating disorder.
5. Based on past treatment history, usual level of functioning and comorbid psychiatric disorders, there is a reasonable expectation that the Covered Individual will benefit from this level of care.
6. Living environment and support are characterized by either significant deficits or significant conflict or problems that would undermine goals of treatment such that treatment at a lower level of care is unlikely to be successful, and this can potentially be improved with treatment.
7. ED PHP criteria also met but no facility within geographic access.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Evaluation by a qualified physician or equivalent professional within 72 hours of admission and at least once weekly visits documented.
2. Physical exam and lab tests done within 72 hours if not done prior to admission and medical availability to manage medical problems if risk for medical instability identified as a reason for admission to this level of care.
3. Programming provided will be consistent with the Covered Individual's language, cognitive, speech and/or hearing abilities.
4. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
5. Within 7 days, an individualized problem focused treatment plan completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex bio-psychosocial evaluation, and this needs to be reviewed at least once a week for progress.
6. Treatment would include the following at least once per day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy and activity group therapy plus at least once weekly individual therapy with a properly licensed provider.
7. Family supports identified and contacted within 72 hours and family/primary support person participation at least

weekly for adults, twice weekly for children and adolescents, unless contraindicated.

8. Discharge planning initiated within one (1) week of admission including identification of community/family resources, connection or re-establishment of connection to an outpatient treatment team and coordination with that team.
9. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their treatment in a community setting.
10. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. If low bodyweight a reason for admission, target weight for safe treatment on an outpatient basis listed and weight gain of 1-2 pounds per week documented.
2. Progress toward treatment goals is documented as shown by motivation on the part of the Covered Individual and family, adherence to treatment recommendations including weight gain and acceptance of recommended dietary caloric intake if low body weight was a reason for admission and control of binging and purging or non-purging bulimic symptoms, but treatment goals that would allow continued treatment at a lower level of care have not been achieved; if progress not achieved than the treatment plan has been adjusted in a manner that is likely to achieve progress toward meeting treatment goals or treatment goals have been adjusted.

EATING DISORDER
PARTIAL HOSPITALIZATION PROGRAM (PHP)

(Co-morbid disorders may influence choice of Level of Care)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Eating Disorder Diagnosis that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. Eating disorder behaviors and body weight are at levels where acute medical intervention is not needed, but without at least six (6) hour daily structured treatment at least five (5) days a week the Covered Individual is likely to regress to needing a higher level of care.
2. Motivation, self care skills and recognition of a need for treatment are sufficient for the Covered Individual to reduce eating disorder behaviors and/or gain weight with outpatient treatment, but has not achieved progress with IOP or outpatient treatment at a twice weekly frequency.
3. If anorexic, restricting and if anorexic or bulimic, binging and purging or non-purging behaviors are present for at least three (3) hours every day and are causing significant functional impairment in at least two domains (work/school, family relations, activities).
4. The Covered Individual has adequate support in their living environment and has access to this level of care.
5. Comorbid psychiatric conditions are stable enough for outpatient treatment and appropriate treatment is being provided to maintain this stability and is not the primary focus of treatment.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Multidisciplinary treatment provided at least six (6) hours daily/ five (5) days a week.
2. A nutritional assessment is done on admission and if low body weight is a reason for admission then specific dietary intake and target weight goals are identified, with once weekly measurement of weight and daily charting of calorie intake/percentage of dietary intake goals.
3. A treatment plan includes targets of cognitive behavioral skills for controlling restricting for Covered Individuals with anorexia, which may include supervised meals, and controlling binging, purging and non-purging behaviors for Covered Individuals with anorexia and bulimia, and progress in gaining and utilizing skills is documented.
4. Evaluation by a qualified physician done upon admission and at least weekly visits are documented.
5. Medical and substance use evaluations are either done on admission or if transferring from another intensive level of care, those evaluations are obtained and recommended interventions incorporated into the treatment plan and appropriate interventions are documented as needed.
6. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
7. Community supports and resources are identified and the treatment plan includes developing or increasing their use.
8. Family therapy is provided at least once per week for children/adolescents and dependant adults and involvement of family members in groups and educational programs is documented (unless contraindicated).
9. Discharge planning including either development of a new outpatient treatment team or coordination with the existing team.
10. The Covered Individual resides in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting. Hours outside of the program are not supervised by any program staff members.
11. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their treatment in a community setting.
12. Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress is documented but treatment goals have not been reached and continued progress and benefit from treatment is likely as shown by the Covered Individual's and family's participation, attendance and evidence of motivation and acceptance of treatment recommendations, and if progress is not being achieved then the treatment plan is being adjusted in such a manner as to likely achieve progress or treatment goals are adjusted that are likely to be achieved.

EATING DISORDER
INTENSIVE OUTPATIENT PROGRAM (IOP)

(Co-morbid disorders may influence choice of Level of Care)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I or ICD-9 Eating Disorder Diagnosis that is consistent with symptoms.

Must have all of the following to qualify:

1. Eating disorder behaviors and body weight are at levels where acute medical intervention is not needed, but without three (3) hour daily structured treatment at least three (3) days a week the Covered Individual is likely to regress or return to needing a higher level of care.
2. Motivation, self care skills and recognition of a need for treatment are sufficient for the Covered Individual to reduce eating disorder behaviors and/or gain weight with outpatient treatment, but has not achieved progress with outpatient treatment up to twice weekly.
3. The Covered Individual has adequate support in their living environment and has access to this level of care.
4. Comorbid psychiatric conditions are stable enough for outpatient treatment and appropriate treatment is being provided to maintain this stability and is not the primary focus of treatment.

INTENSITY OF SERVICE (IS)

Must have all the following:

1. Services are provided by appropriately licensed clinicians for a minimum of three (3) hours/ three (3) days per week.
2. A nutritional assessment is done on admission and if low body weight is a reason for admission then specific dietary intake and target weight goals are identified, with once weekly measurement of weight and daily charting of calorie intake/percentage of dietary intake goals.
3. A treatment plan includes targets of cognitive behavioral skills for controlling restricting for Covered Individuals with anorexia, which may include supervised meals, and controlling binging, purging and non-purging behaviors for Covered Individuals with anorexia and bulimia, and progress in gaining and utilizing skills is documented.
4. Medical, psychiatric and substance use evaluations are either done on admission or if transferring from another intensive level of care, those evaluations are obtained and recommended interventions incorporated into the treatment plan and appropriate interventions are documented as needed.
5. Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and the Covered Individual's PCP, providing treatment to the Covered Individual, and where indicated, clinicians providing treatment to other family members, is documented.
6. Community supports and resources are identified and the treatment plan includes developing or increasing their use.
7. Family therapy is provided at least once per week for children/adolescents and dependant adults and involvement of family members in groups and educational programs is documented (unless contraindicated).
8. Discharge planning including either development of a new outpatient treatment team or coordination with the existing team.
9. The treatment is individualized and not determined by a programmatic timeframe. It is expected that Covered Individuals will be prepared to receive the majority of their treatment in a community setting.
10. The Covered Individual resides in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

Benefit from treatment is likely as shown by the Covered Individual's and family's participation, attendance and evidence of motivation and acceptance of treatment recommendations, and if progress is not being achieved then the treatment plan is

being modified in such a manner as to likely achieve progress.

EATING DISORDER
OUTPATIENT TREATMENT

(Co-morbid disorders may influence choice of Level of Care)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: Current DSM Axis I Diagnosis or ICD-9 that is consistent with symptoms. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following to qualify:

1. Medically stable.
2. >85% healthy body weight or BMI > 18, unless transferred from a higher level of care where previously assessed to be stable as indicated by normal vital signs, no need for IVs or nasogastric feeding, normal lab tests or abnormalities that do not require active medical intervention.
3. Fair to good motivation to recover and cooperative with treatment.
4. Self sufficient in eating/gaining weight and controlling behaviors.
5. Others able to provide adequate support and structure.
6. Lives near treatment setting.

Note: *The severity of illness factors important for distinguishing between PHP, IOP and outpatient is the Covered Individuals' level of insight, social support, motivation, and ability to self-control eating disorder symptoms.*

INTENSITY OF SERVICE (IS)

Must have all the following:

1. Face to face sessions.
2. Treatment plan to address issues involved in the eating disorder including healthy weight and changing body image with specific objective and measurable goals.
3. Coordination with other disciplines to assure nutritional, psychiatric, medical, and substance abuse evaluation and treatment as appropriate.
4. Community resources assessed and recommended, as appropriate.
5. Family therapy is a part of child/adolescent treatment and marital/family therapy for adults by a licensed provider, unless clinically contraindicated.
6. Development of an aftercare/discharge plan.
7. Frequency of visits greater than one time per week is indicated only for crisis stabilization for a period not to exceed 4 weeks unless clinically contraindicated.
8. The frequency of maintenance therapy is less than one time per week.
9. Substance use evaluation and intervention has been completed when appropriate.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

1. Progress with the eating disorder symptoms and behaviors is documented and the Covered Individual is cooperative with treatment and showing evidence of motivation that is consistent with likely continued benefit; if progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

PSYCHIATRIC OUTPATIENT TREATMENT (including treatment provided by a clinician licensed at the independent practice level)

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Interventions will focus on the presenting symptoms and complaints that have led to a decrease in the Covered Individual's usual level of functioning. To qualify, the symptoms must meet the diagnostic criteria for a diagnosis from DSM IV or ICD 9 covered by the Covered Individual's plan.

All must be present:

1. Specific symptoms or disturbances of mood and/or behavior are present, with functional impairment, which are consistent with the DSM/ICD diagnosis listed, and these disturbances/symptoms are likely to improve with treatment.
2. The Covered Individual demonstrates motivation for treatment and is capable of benefiting from the treatment approach planned.

INTENSITY OF SERVICE (IS)

All must be present:

1. Treatment goals target resolution of specific symptoms or stabilization of mood and/or behavior consistent with the DSM/ICD diagnoses listed and also target specific domains of functional impairment.
2. Medication is being used for conditions where indicated, and if not, documentation of the reason and treatment interventions addressing the omission of this treatment.
3. If substance abuse/dependence is a diagnosis or indicated to be present, a substance use evaluation has been performed when appropriate and treatment is being provided.
4. Community/natural supports and resources are identified and utilized or skills to develop community/natural supports is a treatment goal, including school/work interventions, self-help or diagnosis specific support groups, spiritual/religious, and community recreational activities.
5. Coordination of care with other clinicians providing care to the Covered Individual or family members, including psychiatrist/therapist and PCP is documented.
6. For children/adolescents, family participation in treatment or family therapy is documented unless contraindicated with documentation of the reason.
7. Treatment is not duplicative of services being provided by another clinician for the same reasons/diagnoses.
8. Provider must be properly licensed to provide the treatment requested.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" Criteria and have the following to qualify:

Frequency Criteria: for treatment that occurs more frequently than once per week (excluding Medication Management) must have all the following (1 - 3) to qualify:

1. Either the Covered Individual has been discharged from an inpatient, residential or PHP service and more frequent OP treatment is required as a transition for the purposes of stabilization while returning to the community or the Covered Individual is in crisis as evidenced by suicidal ideation or high risk behavior that is manageable on an OP basis, or an unexpected increase in symptoms and/or behaviors or worsening in mood where the treatment goals are focused on stabilization of the crisis.
2. The symptoms/behaviors or mood that represent the crisis can be stabilized with more frequent treatment as evidenced by urgent psychiatric contact and medication changes if indicated and reports of progress with resolving the crisis.
3. The condition has not stabilized to the point where less frequent treatment which targets less critical symptoms/behaviors is equally appropriate.

Frequency Criteria: for treatment up to once per week (excluding Medication Management) must have all the following (4 – 9) to qualify:

4. Progress with the targeted symptoms/behaviors and/or mood is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment, improving severity of symptoms and functional impairment and GAF scores, and continued progress is expected for the targeted symptoms and behaviors or mood with the treatment approaches being used.

5. If progress is not documented, either diagnosis has been re-evaluated and changed if appropriate, medication has been re-evaluated and changed if indicated, or the treatment approach has been re-evaluated and changed if appropriate to include a diagnosis specific therapy, family therapy or new treatment goals/targets.
6. The goals of treatment are not primarily for providing support, targets are not primarily symptoms/behaviors which are either chronic and not likely to improve with the type of treatment being used, or primarily self improvement.
7. Symptoms and/or functional impairment of at least a moderate degree as evidenced by report of specific domains and/or GAF score <_60 are still present related to the DSM/ICD diagnoses listed and likely to improve with continued treatment.
8. The Covered Individual is allowing coordination of care with other providers and evidence of this is documented, and is involving family members where indicated; for children/adolescents, the family is participating in treatment and adhering to recommendations.
9. The condition has not stabilized to the point where maintenance treatment is appropriate, where sustained improvement is not likely and the purpose of continued treatment is to prevent relapse or maintain previous achieved progress.

Frequency Criteria: for treatment every other week, (excluding Medication Management) must have all the following (10 – 11) to qualify:

10. Symptoms/behaviors or mood disturbances persist consistent with the DSM/ICD diagnoses listed which have not remitted as shown by moderate to severe symptoms and functional impairment, that require maintenance treatment to ensure that previously achieved progress in treatment is sustained and where relapse or deterioration is likely without this degree of continued treatment.
11. Maintenance treatment cannot be provided by medication management alone or medication treatment is only partially effective and intermittent therapy support is required in addition to medication maintenance treatment. When treatment frequency is being transitioned from once weekly (or more) to once monthly (or less), a reduction in frequency to maintenance treatment should be done with a brief period of transition to maintain stability.

Frequency Criteria: for treatment once monthly, (excluding Medication Management) must have all the following (12 – 13) to qualify:

12. Symptoms/behaviors or mood disturbances persist consistent with the DSM/ICD diagnoses listed that require maintenance treatment to ensure that previously achieved progress in treatment is sustained and where relapse or deterioration is likely without this degree of continued treatment.
13. Maintenance treatment cannot be provided by medication management alone or medication treatment is only partially effective and intermittent therapy support is required in addition to medication maintenance treatment.

PSYCHIATRIC OUTPATIENT TREATMENT
MEDICATION MANAGEMENT

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Medication management is provided for Covered Individuals who require a medical evaluation and ongoing supervision and prescription of psychotropic medications.

Must have all to qualify:

1. Medical evaluation to determine whether there is a need for medication, and
2. Medical prescription of psychotropic drugs and on-going medication monitoring.
3. Axis I or Axis II diagnoses from DSM IV or Psychiatric Diagnosis for ICD-9.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. The physician meets with the Covered Individual, face to face, on a scheduled basis;
    a. *Acute Covered Individuals* - The physician may see the Covered Individual up to once or twice a week if the Covered Individual is not yet stabilized on medication or is suffering from adverse side effects.
    b. *Stabilized/chronic Covered Individuals* – The physician typically sees the Covered Individual monthly or at least quarterly (or less frequently when stable) when indicated, if the Covered Individual's pharmacological plan is appropriate and the Covered Individual does not experience complications from medication. Up to one year may be certified.
2. A qualified physician, psychiatric nurse practitioner (or physician extender or independently licensed clinician as permitted by law or health plan benefits) as appropriate prescribes the medication.
3. The physician or other prescriber collaborates with a psychotherapist (if there is one) and PCP as appropriate, when a prescription is initiated or changed. Coordination of care should occur at regular intervals and be documented.
4. Adherence to documentation and treatment plan guidelines.
5. Family involvement is a part of child/adolescent management unless clinically contraindicated.
6. Substance use evaluation has been completed when appropriate.

B. CONTINUED STAY CRITERIA (CS)

Must continue to meet "SI/IS" criteria and have all of the following to qualify:

1. Progress is documented and the Covered Individual is cooperative and motivated such that continued progress is expected, and if not then the treatment plan is being changed or if no further progress expected, than a maintenance plan is in effect.

PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Must meet 1 thru 3:

1. Must be for the purpose of helping to establish the diagnosis of and to develop a treatment plan for a mental disorder, when this information is not adequately available from one or more comprehensive behavioral health evaluations with the Covered Individual and appropriate ancillary sources (e.g., family members, health care providers, school records).
2. It should not be for the primary purpose of assessing learning disorders, vocational testing or educational planning, unless allowed by local plan clinical guidelines. Custody evaluation, court referral for evaluation (unless medically necessary) and testing for research purposes, are not covered.
3. There is evidence to suggest that the testing results will have a timely and direct impact on the Covered Individual's treatment plan.

INTENSITY OF SERVICE (IS)

1. The services must be provided by a mental health provider who is licensed in their state of practice to do psychological testing.
2. The provider's assessments, recommendations and reports are based on techniques sufficient to provide appropriate substantiation for their findings. A select test battery is therefore employed and tailored to the specific referral question, rather than the use of a more standard, general battery.
3. Brief rating scales, and standardized questionnaires administered by computer or those not requiring face-to-face administration can be done as part of a professional visit and should not be charged for separately.
4. Only standardized tests that are based upon published national normative data, with scoring resulting in standardized or scaled scores, may be approved.
5. Pre-surgical assessment or suitability for opioid therapy or spinal implant for pain management are limited to three (3) hours (dependent upon plan benefits).
6. The proposed time to administer selected tests should not exceed the administration time established by the tests' publishers, plus time necessary to score, interpret and report.

Note: *Psychological testing for the purpose of assessing or screening Covered Individuals as part of a protocol for a surgical procedure (e.g., gastric by-pass surgery) or pain management program or to assess organic dysfunction related to a brain injury or brain damage is often covered as part of a comprehensive protocol or under the medical benefit. When this is not covered under the medical benefit, it should be reviewed by a physician/psychologist peer clinical reviewer.*

EAP OUTPATIENT TREATMENT CRITERIA

These criteria apply only to California DMHC Regulated Business

A. ADMISSION CRITERIA

SEVERITY OF ILLNESS (SI)

Clinical Findings: The Covered Individual is requesting help with problems that are affecting their work and/or personal life. All services must meet the definition of medical necessity in the Covered Individual's plan document.

Must have all of the following:

1. The focus of treatment is symptom resolution, mood and/or behavior stabilization that is amenable to improvement with brief counseling within the model of their plan.
2. The Covered Individual's problems and/or symptoms do not indicate that they are in imminent need of hospital care due to being a danger to self or others or because they are gravely disabled or are in need of medically supervised detoxification.

INTENSITY OF SERVICE (IS)

Must have all of the following to qualify:

1. Assessment is completed which includes identification of specific problems and/or symptoms and impairment which are affecting the Covered Individual in their work and/or personal life. This should always include a substance abuse assessment and general risk assessment.
2. If appropriate short-term, problem-focused counseling is attempted to resolve the presenting complaint or identified issues.
3. Relevant community resources assessed and recommended as appropriate.
4. When long-term counseling is indicated, referrals are provided and transfer of care is appropriately coordinated.

B. CONTINUED STAY CRITERIA (CS)

Must have the following to qualify:

1. Must continue to meet "SI/IS" Criteria and have the following to qualify:
2. Progress in relation to specific problems and/or symptoms, behaviors and impairments is evident and such as can be resolved within the brief counseling model of their plan.

C. DISCHARGE CRITERIA (DC)

Must have one (1) of the following to qualify:

1. The problems and/or symptoms that originally brought the Covered Individual/family into treatment are improved to the extent that their work and/or personal life are no longer adversely affected.
2. Despite attempts at intervention the Covered Individual's problems and/or symptoms appear pervasive, indicating a need for traditional psychotherapy or some other, more intensive service, as opposed to brief counseling and care of the Covered Individual is transferred to another provider within their health plan network.
3. The Covered Individual is linked to appropriate community resources.

REFERENCES

Peer Reviewed Publications:

1. Kahn, DA, Carpenter D, Docherty JP, Frances A. (1996): The expert consensus guideline series: treatment of bipolar disorder. J Clin Psychiatry, 57 (Suppl 12A).
2. McEvoy JP, Scheifler PL, Frances A. Treatment of schizophrenia 1999. The expert consensus guideline series. J Clin Psychiatry. 1999; 60 Suppl 11:3-80.

Government Agency, Medical Society, and Other Authoritative Publications:

3. Depression in Primary Care: Detection and Diagnosis. Volume 1. Detection and Diagnosis Clinical Guideline Number 5. AHCPR Publication No. 93-0550: April 1993.
4. Hoffman NG, Mee-Lee D, Halikas JA. Patient placement criteria for the treatment of psychoactive substance use disorders. Chevy Chase: American Society of Addiction Medicine. 2001.
5. Level of Care Placement Criteria for Psychiatric Illness (1995). American Academy of Child and Adolescent Psychiatry.
6. Manual of Psychiatric Peer Review (1974). American Psychiatric Association.
7. Mattson M. Manual of psychiatric quality assurance: American Psychiatric Association committee on quality assurance. 1st ed. Arlington: American Psychiatric Publishing. 1992.
8. Practice Guidelines for the Treatment of Psychiatric Disorders (2004). American Psychiatric Association. Washington, DC.
9. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. Intensive outpatient treatment for alcohol and other drug abuse. 1994. DHHS Publication No. (SMA) 94B2077.
10. Treatment of Major Depression. Volume 2. Treatment of Major Depression Clinical Practice Guideline Number 5. AHCPR Publication No. 93-0551: April 1993.
11. Weiner RD. Manual of psychiatric quality assurance. 1st ed. Arlington: American Psychiatric Publishing. 1992. Electroconvulsive therapy guidelines and criteria.
12. Weiner RD. Practice of electroconvulsive therapy: recommendations for treatment, training, and privileging (A task force report of the American Psychiatric Association). 2nd ed. Arlington: American Psychiatric Publishing. 2001.