Medical Necessity Criteria Guidelines

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Preamble - Principles of Medical Necessity Determinations

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan[1] is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual patient's biopsychosocial needs. We see the continuum of care as a fluid treatment pathway, where patients may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active and takes into consideration the patient's stage of readiness to change/readiness to participate in treatment.

The level of care criteria that follow are guidelines for determining medical necessity for the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5™)* disorders. Individuals may at times seek admission to clinical services for reasons other than medical necessity, e.g., to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway/truant behavior, to achieve family respite, etc. However, these factors do not alone determine a medical necessity decision. Further, coverage for services is subject to the limitations and conditions of the member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which medical necessity criteria are applicable.

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

Clinical Judgment and Exceptions

The Magellan Medical Necessity Criteria Guidelines direct both providers and reviewers to the most appropriate level of care for a patient. While these criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions.

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

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

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

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Medical Necessity Definition

Magellan reviews mental health and substance abuse treatment for medical necessity. Magellan defines medical necessity as: *"Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:*

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

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

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

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

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

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Levels of Care & Service Definitions

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

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

1. Hospitalization

a. Hospitalization describes the highest level of skilled psychiatric and substance abuse services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general hospital or a detoxification unit in a hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.
b. This definition also includes crisis beds, hospital-level rehabilitation beds for substance use disorders and 23-hour beds that provide a similar, if not greater, intensity of medical and nursing care. For crisis and 23-hour programs, the psychiatric hospitalization criteria apply for medical necessity reviews. For hospital-level substance abuse rehabilitation, the Hospitalization, Rehabilitation Treatment, Substance Use Disorder criteria set applies. For subacute hospitalization, the Hospitalization, Subacute criteria set applies.

2. Subacute Hospitalization

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

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

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

3. 23-Hour Observation

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

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

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

4. Residential Treatment

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

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

b. Sex Offender Residential Treatment provides a therapeutic treatment program in a 24- hour residential facility for individuals with severe emotional and/or psychological treatment needs as well as a history of sexually assaultive or abusive behavior, sexually reactive behavior, or sexual adjustment issues. This care is medically monitored, with 24-hour medical and nursing services availability. Treatment includes a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. In addition to treating psychiatric conditions, Sexual Offender Residential provides a high level of structure and supervision while offering intensive sex offender-specific treatment that is based on the current research and best practices. The residential program will address sex offender and/or other risk factors that have contributed to the sexually maladaptive behavior with an ongoing emphasis on relapse prevention and victim awareness. An individualized treatment plan is developed to lower recidivism risk and help the patient successfully reintegrate into the community. Residential Care also treats co-occurring mental health disorders through intensive individual, group, and family therapy. Settings that are eligible for this level of care are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level of care may vary by state.

5. Supervised Living

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

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

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

6. Partial Hospitalization

a. These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least 4 hours/day and are available at least 3 days/week. The services include medical and nursing, but at less intensity than that provided

in a hospital setting. The patient is not considered a resident at the program. The range of services offered is designed to address a mental health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

7. Intensive Outpatient Programs

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

8. Outpatient Treatment

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

9. Ambulatory

a. Ambulatory services are outpatient treatment services, provided by qualified mental health professionals and directed toward reversing symptoms of acute mental health disorders, and/or substance use disorders in order to facilitate improvement, maintain stability and increase functional autonomy for persons with various forms of mental health and substance use disorders. Outpatient services are specific in targeting the symptoms or problem being treated. Examples of types of Counseling and Psychotherapy include the following:

- individual psychotherapy
- behavioral therapy
- medication management
- shared medical appointments
- psychiatric, psychological, and psychosocial assessment
- group psychotherapy
- conjoint/marital therapy

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- family therapy.
- outpatient detox services
- outpatient buprenorphine maintenance services

Common settings or sites for these services include providers' offices and clinics.

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Term Definitions

1. Family:

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

2. Support System:

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

3. Significant Improvement:

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

b. Acquire requisite strengths in order to be discharged or move to a less restrictive level of care.

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

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

4. Qualified Healthcare Professional:

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

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5. Physician:

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

6. Geriatric

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

7. Adolescent

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

8. Standardized Screening Tools

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

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Hospitalization, Psychiatric, Adult

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

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

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

1. a current plan or intent to harm self with an available and lethal means, *or*

2. a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*

3. an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*

4. other similarly clear and reasonable evidence of imminent serious harm to self.

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

1. a current plan or intent to harm others with an available and lethal means, *or*

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2. a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*

3. violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*

4. other similarly clear and reasonable evidence of imminent serious harm to others.

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician no more than 24 hours prior to or 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

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

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

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

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Criteria for Continued Stay

III. Continued Stay

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

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

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

2. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or* that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation, *or*

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

B. The current treatment plan includes documentation of a DSM-5 diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the patient's family and/or other support systems, unless there is an identified, valid reason why it is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

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

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

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

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Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

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

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

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

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

1) a current plan or intent to harm others with an available and lethal means, *or*

2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*

3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*

4) other similarly clear and reasonable evidence of imminent serious harm to others.

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician no more than 24 hours prior to or 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation ,*or*

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

B. The current treatment plan includes documentation of a DSM-5 diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

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

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

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

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Hospitalization, Psychiatric, Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

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

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

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

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

1) a current plan or intent to harm others with an available and lethal means, *or*

2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*

3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*

4) other similarly clear and reasonable evidence of imminent serious harm to others.

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician no more than 24 hours prior to or 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living[2], other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation , *or*

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

B. The current treatment plan includes documentation of a DSM-5 diagnosis , individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with caretakers/guardians/family members, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical

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status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

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

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

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Hospitalization, Eating Disorders[3]

Criteria for Admission

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

I. Admission - Severity of Need

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

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

B. One of the following:

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

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

3) while admission to this level of care is primarily based on presence of physiologic instability, generally, patients with a body weight significantly below ideal, e.g., 75 percent of Ideal Body Weight (IBW) or less, will have physiologic instability as described above. However, if body weight is equal

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

to or greater than 75 percent of IBW, Criterion B can be met if there is evidence of any one of the following:

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

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

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

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

C. In anorexia, the patient's malnourished condition requires 24-hour medical/nursing intervention to provide immediate interruption of the food restriction, excessive exercise, purging and/or use of laxatives/diet pills/diuretics to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition or psychiatric condition (e.g., severe depression with suicidal ideation).

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

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

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

2) have physiologic instability and/or significant weight loss (generally, less than 85% IBW), *and*

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

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

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

II. Admission - Intensity and Quality of Service

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

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

B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment including but not limited to medication monitoring and administration, nutritional services, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. For patients diagnosed with Anorexia Nervosa, the treatment plan must include a component for face-to face meal supervision for at least one meal per day during the hospital stay. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

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3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation *or*

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

B. The current treatment plan includes documentation of a DSM-5 diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post- hospitalization needs.

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

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

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

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

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

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Hospitalization, Substance Use Disorders, Detoxification[4]

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

   1) the patient presents with either:

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

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

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

II. Admission - Intensity and Quality of Service

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

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

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This

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

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staffing must provide 24-hour services, including skilled observation and medication administration.

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

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician. Treatment interventions are guided during treatment by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

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

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

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Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a substance use disorder as defined by a DSM-5 diagnosis that is amenable to active behavioral health treatment.

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

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

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

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

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

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

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

F. One of the following must be met:

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

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

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rehabilitation ward setting rather than requiring a medical/surgical ward setting.

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

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

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

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

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a substance use disorder as defined by a DSM-5 diagnosis that is amenable to active behavioral health treatment.

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

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

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

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

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

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

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

F. One of the following must be met:

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

2) the patient is in need of substance use disorder rehabilitation treatment and has a substance-related, acute, co-morbid medical condition(s) that

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currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.

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

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

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II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. An appropriate initial medical assessment and ongoing medical management must be available to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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Subacute Hospitalization, Psychiatric, Adult

Criteria for Admission

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

I. Admission - Severity of Need

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

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

B. Either:

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.

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

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

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

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

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

4) evaluation for current medical problems, *and*

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

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E, F, and G must be met to satisfy the criteria for continued stay.
A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

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Subacute Hospitalization, Psychiatric, Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

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

B. Either:

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

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

C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include, but is not limited to: medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living[5], other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

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

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

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II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.

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

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

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

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

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

4) evaluation for current medical problems, *and*

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

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

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

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

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

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Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

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Subacute Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

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

B. Either:

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.

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

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

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

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

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

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

5) evaluation for current medical problems, *and*

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

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23-Hour Observation

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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C. Clinical interventions emphasize crisis intervention, relapse prevention and motivational strategies with the intent to stabilize the patient and enhance motivation for change utilizing medication management, individual therapy and/or family or other support system involvement (the frequency of which will be determined by what the treatment team believes is needed to stabilize and re-evaluate the patient) with focus on proximal events in a brief solution-focused model.

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

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

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

Criteria for Continued Stay

III. Continued Stay

- Not Applicable

Criteria for Discharge

IV. Discharge Criteria

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

A. The patient meets admission criteria for inpatient hospitalization.

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

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Residential Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

A. There is clinical evidence that the patient has a DSM-5 disorder that is amenable to active psychiatric treatment.

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

C. Either:

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation. As part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.

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

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

1) at least once-a-week psychiatric reassessments, if indicated, *and*
2) weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
4) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*
5) evaluation for concomitant substance use issues, *and*
6) integrated treatment, rehabilitation and support provided by a multidisciplinary team, *and*
7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

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Residential Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

A. There is clinical evidence that the patient has a DSM-5 disorder that is amenable to active psychiatric treatment.

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

C. Either:

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning

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

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

1) at least once-a-week psychiatric reassessments, if indicated, *and*
2) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible, *and*
3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
4) evaluation for current medical problems, *and*
5) evaluation for concomitant substance use issues, *and*
6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

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

Criteria for Continued Stay

III. Continued Stay

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

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

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical

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

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

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

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

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Residential Treatment, Eating Disorders

Criteria for Admission

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

I. Admission - Severity of Need

If patient has anorexia, criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need. If patient has Bulimia or Unspecified Feeding or Eating Disorder, criteria A, B, C, D, and G must be met to satisfy the criteria for severity of need.

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Unspecified Feeding or Eating Disorder. There is clinical evidence that the patient's condition is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorder residential level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.

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

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

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

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

family/support system cannot provide this level of supervision along with a less-intensive level of care setting.

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

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

1) at least once-a-week psychiatric reassessments, if indicated, *and*
2) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
3) psychotropic medications, if medically indicated, to be used with specific target symptoms identified, *and*
4) evaluation and management for current medical problems, *and*
5) evaluation and treatment for concomitant substance use issues, *and*
6) for patients diagnosed with Anorexia Nervosa the treatment plan must include a component for face-to face meal supervision for at least one meal per day during the hospital stay.
7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

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

Criteria for Continued Stay

III. Continued Stay

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

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*
2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

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

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

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Residential Treatment, Substance Use Disorders, Detoxification[6]

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and licensed registered nurse

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

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

C. Treatment must include at least once-a-week psychiatric reassessments, if indicated, *and*

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

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

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

G. Treatment progress is assessed at least daily and treatment interventions are guided during treatment by quantitative measures of withdrawal such as the CIWA-Ar or COWS if applicable.

Criteria for Continued Stay

III. Continued Stay

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

A. Admission criteria continue to be met.

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

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a substance-related disorder as defined by a DSM-5 diagnosis that is amenable to active behavioral health treatment.

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

C. The patient exhibits a pattern of moderate or severe substance use and/or addictive disorder as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. There is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable and related to current abuse of substances such as medical and physical instability which would prohibit safe treatment in a less-intensive setting.

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

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

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

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

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

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does not have significant co-morbid condition(s). G. The patient demonstrates motivation to manage symptoms or make behavioral change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face behavioral health evaluation within the past 48 hours by a psychiatrist or an Addiction Medicine Physician. The patient has been determined to be medically and psychiatrically stable. With the geriatric patient, as part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.

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

C. Treatment includes at least once-a-week psychiatric reassessments, if indicated.

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

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

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

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

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Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a substance-related disorder as defined by a DSM-5 diagnosis that is amenable to active behavioral health treatment.

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

C. The patient exhibits a pattern of moderate or severe substance use and/or addictive disorder as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

D. There is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable and related to current abuse of substances such as medical and physical instability which would prohibit safe treatment in a less-intensive setting.

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

1. despite recent (i.e., the past 3 months), appropriate, professional intervention, at a less-intensive level of care the patient is continually unable to maintain abstinence and recovery, *or*
2. the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intensive level of care and alternative living situations are not available or clinically appropriate, *or*

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

F. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care. The patient does not have significant co-morbid condition(s).

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

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face behavioral health evaluation within the past 48 hours by a psychiatrist or an Addiction Medicine Physician. The patient has been determined to be medically and psychiatrically stable.

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

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

D. Treatment must include at least once-a-week psychiatric reassessments, if indicated.

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

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

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Residential Treatment, Sexual Offender, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient must have either engaged in sexually assaultive or abusive behavior which includes contact offenses against other children, peers, or adults, or have engaged in multiple non-contact offenses (e.g., voyeurism, exhibitionism, possession of child pornographic material, or other sexually maladaptive behaviors).

B. Based on a comprehensive sexual offense specific evaluation, the patient is deemed at risk to reoffend and demonstrates severe and persistent symptoms and functional impairment consistent with a DSM-5 diagnosis that is directly connected to the offending behavior and requires 24-hour residential sexual offender treatment, under the direction of a physician. There is clinical evidence that the DSM-5 disorder is amenable to active sexual offender treatment.

C. There is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program.

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

E. The patient has the cognitive ability to both understand and respond to the treatment provided.

F. Treatment services can reasonably be expected to improve the patient's condition.

G. The patient's current living environment does not provide the support and supervision required for community safety and/or access to therapeutic services needed.

H. Less restrictive community based services have been given a fully adequate trial, and were unsuccessful or, if not attempted, have been considered, but in either

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situation were determined to be to be unable to meet the individual's treatment needs.

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

II. Admission - Intensity and Quality of Service

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

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face diagnostic evaluation by a licensed and trained professional specific to sexual offending. Evaluation requirements must comply with existing state regulations.

B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting. The program should demonstrate the capacity to treat sexually abusive or assaultive behavior and utilize methods of treatment that are rooted in best practices.

C. An individualized plan of active sexual offense specific treatment, mental health treatment, and residential living support is provided in a timely manner and developed in response to evaluation and ongoing assessments. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes all of the following:

1) at least once-a-week psychiatric reassessments, if indicated;

2) measurable treatment goals that address strengths, sex-offense specific risk management, and areas of need;

3) intensive family and/or support system involvement occurring on a weekly basis, or identifies valid reasons why such a plan is not clinically appropriate or feasible;

4) psychotropic medications, when used, are to be used with specific target symptoms identified;

5) evaluation for current medical problems;

6) evaluation for concomitant substance use issues;

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

8) long term after-care and support plan that supports recovery goals as well as addresses recidivism risks.

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

Criteria for Continued Stay

III. Continued Stay

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

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

1) the patient's level of risk and needs that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness or sexually abusive or assaultive behavior to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. The services continue to be reasonably expected to improve the patient's further decrease dynamic risk factors, or prevent further regression so that residential services will no longer be needed.C. The active treatment plan includes intensive family interventions and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

D. The patient's level of risk and needs cannot be appropriately and safely delivered at a less restrictive level of care.

E. An updated multidisciplinary treatment plan and assessment of risks factors is completed and documented at least every 30 days or more often whenever clinically indicated.

F. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation.

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

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H. A discharge plan is formulated that is directly linked to the risks and needs, behavioral symptoms and/or clinical issues that resulted in admission, and begins to identify specific aftercare plans, including community reintegration using community resources, supervision, monitoring and appropriate post-residential treatment resources.

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

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Supervised Living, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a primary DSM-5 diagnosis of a mental illness which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation and support.

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

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

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

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

B. The therapeutic focus of treatment should be on the "here and now" and on encouragement of new activities and initiatives.

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

1) inpatient admission, *or*

2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety,

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self-care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

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

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

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

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Supervised Living, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a primary DSM-5 diagnosis of an emotional/psychiatric disturbance and/or significant behavioral problem which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in a supportive home environment in conjunction with medically necessary treatment, rehabilitation and support.

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

   1) inpatient admission, *or*

   2) harm to self or others.

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

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a primary DSM-5 diagnosis of a substance-related disorder which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation and support.

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

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

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

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

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

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

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

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

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

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

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II. Admission - Intensity and Quality of Service

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

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

B. The therapeutic focus of treatment should be on the "here and now" and on encouragement of new activities and initiatives.

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

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

1) inpatient admission, *or*

2) harm to self or others.

C. There is evidence that the resources and social support system which are available to the patient outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed to

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promote recovery and for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge/disposition planning.

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

E. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a primary DSM-5 diagnosis of a substance-related disorder which is the cause of significant functional and psychosocial impairment and the patient's clinical condition can be expected to be stabilized through the provision of medically necessary supervised residential services in a supportive home environment in conjunction with medically necessary treatment, rehabilitation and support.

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

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

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

   1) inpatient admission, *or*

   2) harm to self or others.

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

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

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

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

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

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

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Partial Hospitalization, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

C. Either:

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

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

D. Additionally, either:

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

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

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

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II. Admission - Intensity and Quality of Service

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

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
The **initial psychiatric evaluation** with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalizationservices. If the patient is being discharged from an inpatient psychiatric admission to a partial hospitalizationprogram, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

B. In order to support the medical necessity of admission to the partial hospital program, the documentation in the initial psychiatric evaluation should include the following items:
- Patient's chief complaint; DSM-5 or ICD-10 diagnosis;
- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity,thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgment, capacity for activities of daily living (ADLs);
- Physical examination (if not done within the past 30 days and available for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the partial hospitalization program;
- Treatment plan, including long and short term goals related to the active treatment of the reason for admission, and types, amount, duration, and frequency of therapy services, including activity therapy required to address the goals.

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

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

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

F. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should include caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants' work schedules or other difficulties make face-to-face sessions impractical. The treatment plan is prescribed and signed by the physician. The plan identifies treatment goals, describes coordination of services, and is structured to meet the particular needs of the patient. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to active treatment.

G. Therapeutic activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

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

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

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

C. The progress note must be written by the team member rendering the service, including the credentials of the rendering provider, and must include the following:
    1. the type of service rendered
    2. the problem/functional defecit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/defecit identified in the treatment plan
    3. the content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal
    4. the patient's status duirng the session
    5. the patient's response to the therapeutic intervention, including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms.

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

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

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

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Partial Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

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

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

C. Either:

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

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

D. Additionally, either:

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

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

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

II. Admission - Intensity and Quality of Service

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

A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours. The **initial psychiatric evaluation** with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalizationservices. If the patient is being discharged from an inpatient psychiatric admission to a partial hospitalizationprogram, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

B. In order to support the medical necessity of admission to the partial hospital program, the documentation in the initial psychiatric evaluation should include the following items:

- Patient's chief complaint; DSM-5 or ICD-10 diagnosis.
- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity,thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgment, capacity for activities of daily living (ADLs);
- Physical examination (if not done within the past 30 days and available for inclusion in the medical
- record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the partial hospitalization program;
- Treatment plan, including long and short term goals related to the active treatment of the reason for admission, and types, amount, duration, and frequency of therapy services, including activity therapy required to address the goals.

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

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

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

F. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. The treatment plan is prescribed and signed by the physician. The plan identifies treatment goals, describes coordination of services, and is structured to meet the particular needs of the patient. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to active treatment.

G. Therapeutic activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

C. The progress note must be written by the team member rendering the service, including the credentials of the rendering provider, and must include the following:

1) the type of service rendered

2)The problem/functional defecit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/defecit identified in the treatment plan

3)The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal

4)The patient's status duirng the session

5) The patient's response to the therapeutic intervention, including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms.

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

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

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

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Partial Hospitalization, Eating Disorders

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Unspecified Feeding or Eating Disorder . There is clinical evidence that the patient's condition can be expected to improve and/or not worsen through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of an appropriate DSM-5 diagnosis.

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

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

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

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

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

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

E. The patient has anorexia; he or she is between 75-85 percent of his or her ideal body weight (IBW) and clinical evidence indicates the patient requires a structured program— including medical monitoring and nursing supervision during and

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between two meals per day to gain weight and/or control eating disorder behaviors—that cannot be provided in a less-intensive outpatient setting.

II. Admission - Intensity and Quality of Service

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

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

   The **initial psychiatric evaluation** with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalizationservices. If the patient is being discharged from an inpatient psychiatric admission to a partial hospitalizationprogram, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

B. In order to support the medical necessity of admission to the partial hospital program, the documentation in the initial psychiatric evaluation should include the following items:

- Patient's chief complaint; DSM-5 or ICD-10 diagnosis.
- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity,thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgment, capacity for activities of daily living (ADLs);
- Physical examination (if not done within the past 30 days and available for inclusion in the medical
- record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the partial hospitalization program;
- Treatment plan, including long and short term goals related to the active treatment of the reason for admission, and types, amount, duration, and frequency of therapy services, including activity therapy required to address the goals.

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

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

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

F. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. If the patient has anorexia, a specific treatment goal of this team is to help the patient gain weight and develop the capability to continue this weight gain upon returning to a less-intensive level of care. For patients diagnosed with Anorexia Nervosa, the treatment plan must include a component for face-to face meal supervision for at least one meal per day during the partial hospital stay. If the patient has bulimia, the goal is to help the patient develop internal controls to limit binging and purging to a degree sufficient to allow the patient to transition to a less-intensive level of care. The treatment plan is prescribed and signed by the physician. The plan identifies treatment goals, describes coordination of services, and is structured to meet the particular needs of the patient. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to active treatment.

G. Therapeutic activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

C. The progress note must be written by the team member rendering the service, including the credentials of the rendering provider, and must include the following:

1) the type of service rendered

2)The problem/functional defecit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/defecit identified in the treatment plan

3)The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal

4)The patient's status duirng the session

5) The patient's response to the therapeutic intervention, including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms.

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

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

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

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Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-5 criteria and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

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

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

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

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

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

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II. Admission - Intensity and Quality of Service

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

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

The **initial psychiatric evaluation** with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalizationservices. If the patient is being discharged from an inpatient psychiatric admission to a partial hospitalizationprogram, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

B. In order to support the medical necessity of admission to the partial hospital program, the documentation in the initial psychiatric evaluation should include the following items:

- Patient's chief complaint; DSM-5 or ICD-10 diagnosis.
- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity,thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgment, capacity for activities of daily living (ADLs);
- Physical examination (if not done within the past 30 days and available for inclusion in the medical
- record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the partial hospitalization program;
- Treatment plan, including long and short term goals related to the active treatment of the reason for admission, and types, amount, duration, and frequency of therapy services, including activity therapy required to address the goals.

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

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

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

F. The individualized plan of substance use rehabilitation treatment for partial hospitalization requires treatment by a multidisciplinary team. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants work schedule or other difficulties make face-to-face sessions impractical. The treatment plan is prescribed and signed by the physician. The plan identifies treatment goals, describes coordination of services, and is structured to meet the particular needs of the patient. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to active treatment.

G. Therapeutic activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

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

I. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.[7]

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

C. The progress note must be written by the team member rendering the service, including the credentials of the rendering provider, and must include the following:

1) the type of service rendered

2)The problem/functional defecit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/defecit identified in the treatment plan

3)The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal

4)The patient's status duirng the session

5) The patient's response to the therapeutic intervention, including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms.

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

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-5 criteria and is mentally competent and has sufficient cognitive ability at this time to benefit from admission to a partial hospitalization program.

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

The **initial psychiatric evaluation** with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalizationservices. If the patient is being discharged from an inpatient psychiatric admission to a partial

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hospitalizationprogram, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

B. In order to support the medical necessity of admission to the partial hospital program, the documentation in the initial psychiatric evaluation should include the following items:

- Patient's chief complaint; DSM-5 or ICD-10 diagnosis.
- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity,thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgment, capacity for activities of daily living (ADLs);
- Physical examination (if not done within the past 30 days and available for inclusion in the medical
- record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the partial hospitalization program;
- Treatment plan, including long and short term goals related to the active treatment of the reason for admission, and types, amount, duration, and frequency of therapy services, including activity therapy required to address the goals.

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

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

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

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The individualized plan of substance use rehabilitation treatment for partial hospitalization requires treatment by a multidisciplinary team. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. The plan identifies treatment goals, describes coordination of services, and is structured to meet the particular needs of the patient. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to active treatment.

F. . Therapeutic activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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C. The progress note must be written by the team member rendering the service, including the credentials of the rendering provider, and must include the following:

1) the type of service rendered

2)The problem/functional defecit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/defecit identified in the treatment plan

3)The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal

4)The patient's status duirng the session

5) The patient's response to the therapeutic intervention, including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms.

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

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

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

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

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

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Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment.

B. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy.

C. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program. If there is a concern the patient may have cognitive challenges which impact their ability to complete the program effectively, then assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment (MMSE, MOCA). After the cognitive assessment the treatment plan should address the cognitive issue such that significant progress is likely to be made.

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

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

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

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

E. Either:

1) for patients with persistent or recurrent disorders, the patient's past history or current clinical evidence indicates that when the patient has experienced similar clinical circumstances either less-intensive treatment was not or likely would not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others. Subjective opinions without objective clinical information or

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

2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

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

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

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Criteria for Continued Stay

III. Continued Stay

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

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

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

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

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

4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment.

B. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy.

C. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program. If there is a concern the patient may have cognitive challenges which impact their ability to complete the program effectively, then assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment (MMSE, MOCA). After the cognitive assessment the treatment plan should address the cognitive issue such that significant progress is likely to be made.

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

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

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

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

E. Either:

1) for patients with persistent or recurrent disorders, the patient's past history or current clinical evidence indicates that when the patient has experienced similar clinical circumstances either less-intensive treatment was not, or likely would not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others. Subjective opinions without objective clinical information or

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

2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

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

   4) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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Intensive Outpatient Treatment, Eating Disorders

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Unspecified Feeding or Eating Disorder. There is clinical evidence that the patient's condition can be expected to improve through medically necessary and appropriate therapy. The patient has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

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

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

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

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

C. Either of the following:

1) for patients with a persistent or recurrent eating disorder, the past history or current clinical evidence indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing threats to the patient's medical stability. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation, *or*

2) for patients with an acute eating disorder crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration,

stabilize the eating disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

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

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Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

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

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

E. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.[9]

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

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment. Subjective opinions are NOT sufficient to meet severity of need. There must be objective clinical evidence or objective information to justify the expectation that there would be a decompensation.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting

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

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

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

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

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The clinical evaluation indicates that the patient has a primary DSM-5 diagnosis(es) of substance-related disorder meeting DSM-5 criteria, and has sufficient cognitive ability at this time to benefit from admission to an intensive outpatient program.

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

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

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

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

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

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

II. Admission- Intensity and Quality of Service

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

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

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

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

D. A Urine Drug Screen (UDS) is considered at least weekly or biweekly on a random basis, or more often as clinically warranted.[10]

Criteria for Continued Stay

III. Continued Stay

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

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

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

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

3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

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

C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by

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

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

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

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

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Ambulatory, Substance Use Disorders, Detoxification[11]

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a recent history and pattern of continuous use of substances that have withdrawal syndromes and requires medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that they do not require 24-hour access to physician and/or nurse monitoring, nor a history of medically complicated withdrawal in the past.

B. Presence of mild to moderate withdrawal symptoms which may be safely managed outside a residential or inpatient setting as evidenced by:

   1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*

   2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*

   3) a CIWA-Ar score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*

   4) family and/or social support is available to assist the patient during detoxification.

C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

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

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

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

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B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

C. Documentation that blood and/or urine drug screen is ordered upon commencement of treatment.

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

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

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

Criteria for Continued Stay

III. Continued Stay

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

A. Admission criteria continue to be met.

B. The patient's condition does not require a higher level of care.

C. Documentation of signs, symptoms and improvement in withdrawal symptoms are noted, and the treatment plan is re-evaluated and modified as medically appropriate.

D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.

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

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

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Ambulatory, Substance Use Disorders, Buprenorphine Maintenance

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

Criteria for Admission

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

I. Admission - Severity of Need

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

A. The patient has a recent history and pattern of continuous use of opioid substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that they do not require 24-hour access to physician and/or nurse monitoring, nor is there a history of medically complicated withdrawal in the past.

B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:

1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, such as alcohol or sedative-hypnotics dependence, and

2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, and

3) a COWS score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, and

4) family and/or social support is available to assist the patient during detoxification

C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

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

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A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician who carries the correct Buprenorphine DEA waiver.

B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

C. Documentation that blood and/or urine drug screen is ordered upon commencement of treatment.

D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs, including encouragement of member to participate in substance use disorder counseling and/or appropriate support resources, such as 12-step type formats and cognitive based formats.

E. Treatment interventions are guided by quantitative measures of withdrawal such as COWS.

Criteria for Continued Stay

III. Continued Stay

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

A. Admission criteria continue to be met.

B. The patient's condition does not require a higher level of care.

C. Documentation of signs, symptoms and improvement in steadfast opioid sobriety and abstinence with the ongoing assessment and treatment plan addressing, re-evaluating, and modified as medically appropriate to ensure continued sober success.

D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate. Use of random blood and/or urine drug screen is a component of monitoring for adherence to treatment recommendations.

E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-maintenance needs. This plan includes attempts to link to outpatient primary care and ongoing behavioral health counseling (addressing appropriate mental health and substance disorder needs) after obtaining patient consent).

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

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

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

Criteria for Authorization

I. Severity of Need

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

A. The patient has a diagnosed or suspected substance use disorder. Presence of the illness(es) must be documented through the assignment of an appropriate DSM-5 diagnosis.

B. Screening uses a multi-panel qualitative assay screening approach (e.g., 'Drugs of Abuse 10 Panel'[12], corresponding to CPT code 80100, 80101 and 82055 for alcohol).

C. Screenings occur upon admission to the substance use disorder rehabilitation program and at ten (10) day intervals to monitor program compliance. Testing at more frequent intervals must be accompanied by documentation of reasons of medical/clinical necessity.

D. Specific drug quantitation can be performed only when there is an acute change in medical status or drug toxicity must be ruled out.

E. Quantitative testing of serum methadone levels may be performed only under the following circumstances:

1) patient is in stabilization phase and requesting an increase over 80mg of methadone, *or*

2) a patient is in maintenance phase and requesting significant dose changes, *or*

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

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3) clinician suspects that a patient is experiencing a drug-drug interaction involving Methadone, *or*

4) clinician is considering split dosing of methadone for the patient, *or*

5) patient is pregnant, and clinician identifies need to screen for changes in metabolism of methadone.

F. Quantitative testing of a limited number drugs may be performed for the purpose of monitoring therapeutic response when the drug is being used as a mood stabilizer or to control a seizure disorder:
   1) Carbamazepine
   2) Clozapine
   3) Dipropylacetic acid
   4) Lithium
   5) Phenytoin

II. Exclusions

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

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Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation

Criteria for Treatment Status Review

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

I. Severity of Need

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

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

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

C. One of the following:

1) the patient has symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, academic, or social), that are the direct result of a DSM-5 diagnosis. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas, *or*

2) the patient has a persistent illness described in DSM-5 with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure, *or*

3) there is clinical evidence that a limited number of additional treatment sessions are required to support termination of therapy, although the patient no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (such as increasing time between appointments, use of community resources, and supporting personal success).

D. The patient does not require a higher level of care.

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

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

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G, H, I, J, and K must be met to satisfy the criteria for intensity and quality of service. In addition, L and M must also be met for substance use disorders.

A. There is documentation of a DSM-5 diagnosis. The assessment also includes the precipitating event/presenting issues, specific symptoms and functional impairments, community and natural resources, personal strengths, and the focus of treatment.

B. There is a medically necessary and appropriate treatment plan, or its update, specific to the patient's behavioral, psychological, and/or biological dysfunctions associated with the DSM-5 psychiatric/substance-related disorder(s). The treatment plan is expected to be effective in reducing the patient's occupational, academic or social functional impairments and:

1) alleviating the patient's distress and/or dysfunction in a timely manner, *or*

2) achieving appropriate maintenance goals for a persistent illness, *or*

3) supporting termination.

C. The treatment plan must identify all of the following:

1) treatment modality, treatment frequency and estimated duration;

2) specific interventions that address the patient's presenting symptoms and issues;

3) coordination of care with other health care services, e.g., PCP or other behavioral health practitioners;

4) the status of active involvement and/or ongoing contact with patient's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible;

5) the status of inclusion and coordination, whenever possible, with appropriate community resources;

6) consideration/referral/utilization of psychopharmological interventions for diagnoses that are known to be responsive to medication;

7) documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological, and/or biological dysfunctions associated with the DSM-5 psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals and specific measurable end of treatment goals, or specific measurable maintenance treatment goals (if this is maintenance treatment),

are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress;

8) the description of an alternative plan to be implemented if the patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are psychiatric evaluation if not yet obtained, a second opinion, or introduction of adjunctive or different therapies; and

9) the current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.

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

E. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.

F. Although the patient has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.

G. Treatment is effective as evidenced by improvement in SF-BH, CHI, and/or other valid outcome measures.

H. Requested services do not duplicate other provided services.

I. Visits for this treatment modality are recommended to be no greater than one to two sessions per week, except for: (i) acute crisis stabilization, or (ii) situations where the treating provider demonstrates more than one visit per week is medically necessary.

J. As the patient exhibits sustained improvement or stabilization of a persistent illness, frequency of visits should be decreased over time (e.g., once every two weeks or once per month) to reinforce and encourage self-efficacy, autonomy, and reliance on community and natural supports.

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

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

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

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Outpatient Applied Behavior Analysis

Introduction

The following Medical Necessity Criteria (MNC) is provided as guideline for coverage decisions. Policies can be highly technical and complex and are provided here for informational purposes (see Appendix). The policies do not constitute medical or behavioral health advice or care. Treating health care providers are solely responsible for diagnosis, treatment and advice consistent with evidence based care and clinical best practices. 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 were developed after extensive review of the available literature on the provision of Applied Behavior Analysis (ABA) for the treatment of autism. A multidisciplinary committee of health care professionals within and external to Magellan Health developed and approved the guidelines based on this review. The guidelines were developed in consultation with experts in the treatment of autism from major research and treatment centers like The Mind Institute at UC Davis, Baylor University and Duke University. The guidelines rely heavily on known best practices in the treatment of developmental disorders including the requirement for a complete assessment utilizing validated tools and standardized developmental norms; symptom focused interventions; caregiver participation and measureable goals (additional information is available in the Appendix).

Description of the Technology

Applied Behavior Analysis is a discipline that applies human behavior principles in various settings, i.e., clinics, schools, homes, and communities, to diminish substantial deficits in a recipient's adaptive functioning or significant Behavior problems due to autism spectrum disorder. This technique applies interventions to address three core areas of behavioral functioning:

1. Deficits in developmentally appropriate self-care include; but are not limited to:
    a. Feeding
    b. Grooming
    c. Activities of daily living (e.g. dressing, preparing for school)
    d. Preoccupation with one or more restricted, stereotyped patterns of behavior that are abnormal in intensity or focus
    e. Inflexible adherence to specific, nonfunctional routines or rituals
    f. Stereotyped, repetitive motor mannerisms
    g. Persistent preoccupation with parts of objects

2. Impairments in social adaptive skills include; but are not limited to:
    a. Delay in or lack of spoken language
    b. Inability to sustain adequate conversation with others
    c. Impairment in non-verbal behaviors in social interaction
    d. Failure to develop peer relationships

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e. Lack of spontaneous seeking to share emotions in relationships
f. Lack of social or emotional reciprocity

3. Prevention of harm to self or others (safety concerns)include; but are not limited to:
   a. Aggression directed to self of others (e.g. hitting, biting)
   b. Engaging in dangerous behaviors (e.g. eating nonfood items, running into the street, elopement)

The first demonstrations of the effectiveness of this treatment model occurred in the 1960's with the employment of highly structured operant conditioning learning programs to improve the condition of recipients with autism and mental retardation. Many techniques, strategies, and approaches have been developed using ABA as a foundation. ABA treatments derive from the experimental analysis of behavior – a field dedicated to understanding how environmental events affect behavior.

ABA systematically applies interventions based on learning theory to improve social interaction, verbal and nonverbal communication, and maladaptive or challenging behavior while demonstrating that the interventions employed are responsible for the improvement. Deficits in functioning may be due to environmental factors, physical conditions, mental health disorders, and psychological factors. The severity and frequency of maladaptive behavior, e.g., aggression, violence, destructiveness, and self-injury, may result in risk to the physical safety of the individual or others. Applied Behavior Analysis involves the analysis, design, implementation, and evaluation of Behavior modification plans to produce significant improvement in behavior. ABA programs include multiple techniques (e.g., discrete trial training and naturalistic teaching) and integrate different strategies based on the recipient's needs and target goals. The ABA literature universally cites the need for caregiver training and caregiver assumption of treatment interventions. ABA methodologies incorporate data collection to monitor the recipient's progress and evaluate the effectiveness of the intervention.

General ABA Behavior goals in autism include: (1) increasing selected behaviors (2) teaching new skills (3) maintaining selected behaviors (4) generalizing or transferring selected behaviors (5) restricting or narrowing conditions under which interfering behaviors occur (6) reducing interfering behaviors and (7) parental skill development and the application of those skills in natural settings. Socially significant behaviors frequently targeted include, addressing underlying issues that impair academic functioning, social skills, communication and adaptive living skills – e.g., gross and fine motor skills, eating and food preparation, toileting, dressing, personal self-care, domestic skills, time and punctuality, money and value, home and community orientation and work skills.

Functional Behavior Analysis (FBA) or functional assessment is a rigorous method of gathering information about problem behaviors. The underlying theory of FBA is that most problem behaviors serve some type of an adaptive function reinforced by consequences. FBA is used in both designing a Behavior program for maximum effectiveness and serves as the foundation of the individualized treatment plan.

The decision about the need for comprehensive versus focused interventions is generally determined, in part, by an evaluation of the level of impairment as demonstrated on

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validated developmental assessment tools. The severity of impairment is often based on how far the person's scores are from the mean (average). A customary statistic for describing how far someone is from the mean, is the standard deviation score (SD). SD scores of less than 1 are considered within the range of normal development. A SD score of 1, but less than 1.5 is considered mild impairment, 1.5 but less than 2 is considered moderate impairment, and 2 or more is considered severe). Another significant factor in this decision is the number of developmental areas affected. For example if only one 1 or 2 areas are affected a focused intervention may be the most appropriate.

Definitions

Comprehensive Intervention: Services may range from 21 to 40 hours per week, early in the recipient's development (for example, under the age of 7). Services are provided for multiple targets across most or all developmental domains. Comprehensive interventions may close the gap between a recipient's level of functioning and that of a typically developing peer. The standard of care for comprehensive services has been for durations of 1 to 2 years.

Focused Intervention: Services are provided up to 20 hours per week and are directed to a more limited set of problematic behaviors or skills deficits in areas such as self-care, communication and personal safety. Focused services introduce and strengthen more adaptive behaviors in order to addressspecific behaviors that are problematic for the recipient

Functional behavior analysis (FBA): A functional assessment that is a rigorous method of gathering information about adaptive functioning and dysfunctional behaviors. The underlying theory of FBA is that most problem behaviors serve some type of an adaptive function reinforced by consequences. FBA is used in both designing a Behavior program for maximum effectiveness and guides development of an individualized treatment plan.

Criteria to Initiate Care

All of following criteria must be met:

1. There is an established and current (within 24months) DSM-5 diagnosis of Autism Spectrum Disorder using validated assessment tools (e.g., Autism Diagnostic Observation Schedule (ADOS), Autism Diagnostic Interview (ADI-R), Parent Evaluation Developmental Stages (PEDS), Checklist for Autism in Toddlers (M-CHAT), Ages and Stages Questionnaire (ASQ), or Brigance); and
2. Developmental assessment has been completed within the last 12 months using validated assessment tools (e.g. Vineland, ABAS).
3. As determined by validated developmental assessment tools, the eligible recipient cannot participate at an age appropriate level in home, school or community activities because of the presence of behavioral excess and/or the absence of functional skills that interfere with participation in these activities[13], and the target behaviors or skill deficits identified for ABA intervention meet one or more of the following:

[13] Additional information on age appropriate skills can be found in the Appendix.

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   a. The target behavior or skill is 1 standard deviation or more below the mean, or
   b. Represents a behavior that poses significant threat of harm to the recipient or others.

4. There is an expectation on the part of a qualified treating health care professional, who has completed an initial evaluation of the recipient that the individual's behavior and skills will improve to a clinically meaningful extent, in at least two settings (home, school, community) with ABA therapy provided by, or supervised by, a certified ABA provider.
5. A functional assessment using validated tools has been completed by a qualified behavior analyst certified by the Behavior Analyst Certification Board (BACB). This assessment will include baseline information on the recipient's adaptive functioning within the last 12 months.
6. The recipient's caregivers commit to participate in the goals of the treatment plan.
7. The recipient is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care
8. There is a treatment plan with the following elements:
   a. There are specific, quantifiable goals, that relate to developmental deficits or behaviors that pose a significant risk of harm to the recipient or others.
   b. Objective, observable, and quantifiable metrics are utilized to measure change toward the specific goal behaviors.
   c. Documentation that adjunctive treatments (e.g., psychotherapy, social skills training, medication services, educational services) have been considered for inclusion in the treatment plan, with the rationale for exclusion.

Criteria for Continued Care

All of the following criteria must be met:

1. The recipient shows improvement from baseline in skill deficits and problematic behaviors targeted in the approved treatment plan using validated assessments of adaptive functioning.
2. As determined by validated developmental assessment tools, the eligible recipient still cannot participate at an age appropriate level in home, school or community activities because of the presence of behavioral excess and/or the absence of functional skills that interfere with participation in these activities, and the target behaviors or skill deficits identified for ABA intervention meet one or more of the following:
   a. The target behavior or skill is 1 standard deviation or more below the mean, or
   b. Represents a behavior that poses significant threat of harm to the recipient or others.

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3. The recipients' caregivers demonstrate continued commitment to participation in the recipient's treatment plan and demonstrate the ability to apply those skills in naturalized settings as documented in the clinical record.
4. The gains made toward developmental norms and Behavior goals cannot be maintained if care is reduced.
5. Behavior issues are not exacerbated by the treatment process.
6. The recipient has the required cognitive capacity to benefit from the care provided and to retain and generalize treatment gains.

Criteria for Discharge from Care

One of the following criteria must be met:

1. The recipient shows improvement from baseline in targeted skill deficits and problematic behaviors such that goals are achieved or maximum benefit has been reached.
2. Caregivers have refused treatment recommendations.
3. Behavioral issues are exacerbated by the treatment.
4. Recipient is unlikely to continue to benefit or maintain gains from continued care.

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Psychological Testing

Criteria for Authorization

The purpose of psychological testing includes, but is not limited to: assisting with diagnosis and management following clinical evaluation when a mental illness or psychological abnormality is suspected; providing a differential diagnosis from a range of neurological/psychological disorders that present with similar constellations of symptoms, e.g., differentiation between pseudodementia and depression; determining the clinical and functional significance of a brain abnormality; or deliniating the specific cognitive basis of functional complaints.

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

I. Severity of Need

Criteria A, B, and C must be met:

A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.

B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.

C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment.

II. Intensity and Quality of Care

Criteria A and B must be met:

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

B. Requested tests must be standardized, valid and reliable in order to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in *Standards for Educational and Psychological Testing.*

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III. Exclusion Criteria

Psychological testing will not be authorized under any of the following conditions:

A. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process.

B. Used as screening tests given to the individual or to general populations.

C. Administered for educational or vocational purposes that do not establish medical management.

D. Performed when abnormalities of brain function are not suspected.

E. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized), e.g., AIMS, Folstein Mini-Mental Status Examination.

F. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy).

G. Administered when the patient has a substance abuse background and any of the following apply:

1) the patient has ongoing substance abuse such that test results would be inaccurate, or
2) the patient is currently intoxicated.

H. The patient has been diagnosed previously with brain dysfunction, such as Alzheimer's diseases and there is no expectation that the testing would impact the patient's medical management.

I. The test is being given solely as a screening test for Alzheimer's disease.

J. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.

K. The testing is primarily for diagnosing attention-deficit hyperactive disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.

L. Testing is primarily for legal purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing.

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M. Requested tests are experimental, antiquated, or not validated.

N. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.

O. More than eight hours per patient per evaluation is considered excessive and supporting documentation in the medical record must be present to justify greater than eight hours per patient per evaluation.

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Therapeutic Leave of Absence Documentation

A Therapeutic Leave of Absence (TLOA) is any leave from a facility, which is ordered by a physician, is medically necessary, and is not supervised by staff. A leave for medical reasons (e.g., consultations, evaluations, office visits and treatments) is excluded from this definition.

Documentation Guidelines

To ensure that a TLOA is recognized as meeting the above definition, the medical record must contain the following information:

1) a physician must order each TLOA, identify it as a TLOA, and specify the number of leave hours approved, *and*

2) therapeutic rationale must be included in the ITPs and/or physician progress notes, and/or social worker notes, *and*

3) the nurse, physician, or social worker must document the outcome of the TLOA in the medical record.

Medical Necessity

While these guidelines address the documentation of therapeutic leaves of absence, the medical necessity of each leave of absence continues to be determined by the application of the Psychiatric Hospitalization Criteria.

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Outpatient Electroconvulsive Therapy

Criteria for Authorization

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

I. Severity of Need

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

A. The clinical evaluation indicates that the patient has a DSM-5 diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient's medical status, the treatment history and the patient's preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s)of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*

3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*

4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

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E. All:

1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *and*

2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course, *and*

3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.

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

II. Intensity and Quality of Service

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

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

1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*

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

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

1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*

2) required modifications in medications or standard anesthetic technique, if any.

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

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

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2) choice of electrode placement during ECT, *and*

3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

1) seizure duration, including missed, brief, and/or prolonged seizures, *and*

2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

3) electrocardiographic activity, *and*

4) vital signs, *and*

5) oximetry, *and*

6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

1) cardiovascular effects, *and*

2) prolonged seizures, *and*

3) respiratory effects, including prolonged apnea, *and*

4) headache, muscle soreness, and nausea.

F. There are post-ECT stabilization and recovery services, including:

1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

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Criteria for Continued Treatment

III. Continued Stay

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

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
   1) the persistence of problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*

   2) the emergence of additional problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

   3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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Inpatient Electroconvulsive Therapy

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of "last resort."

I. Severity of Need

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a DSM-5 diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient's medical status, the treatment history and the patient's preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*

3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*

4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. Either:

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1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *or*

2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*

2) medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*

2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:

1) specific medications to be administered during ECT, *and*

2) choice of electrode placement during ECT, *and*

3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

1) seizure duration, including missed, brief and/or prolonged seizures, *and*

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2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

3) electrocardiographic activity, *and*

4) vital signs, *and*

5) oximetry, *and*

6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

1) cardiovascular effects, *and*

2) prolonged seizures, *and*

3) respiratory effects, including prolonged apnea, *and*

4) headache, muscle soreness and nausea.

F. There are post-ECT stabilization and recovery services, including:

1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B, and C must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

1) the persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*

2) the emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*

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3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

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Transcranial Magnetic Stimulation Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for transcranial magnetic stimulation (TMS).

I. Severity of Need

Criteria A, B, C, D, E, F, G, H, and I must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the adult patient has a DSM-5 diagnosis of a major depressive disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate TMS treatment.

B. TMS will be used only for adults over the age of 22 who are not pregnant.

C. An evidence-based psychotherapy for depression was attempted of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms.

D. One or more of the following:

1) the patient has demonstrated medication treatment-resistance during the current depressive episode as evidenced by a lack of clinically significant response to four trials of psychopharmacologic agents in the current depressive episode from at least two different agent classes at or above the minimum effective dose. At least one of the treatment trials must have been administered at an adequate course of mono- or poly-drug therapy; *or*

2) the patient has demonstrated an inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents from at least two different agent classes, with distinct side effects. *or*

3) the patient has a history of good response to TMS during an earlier episode of the treatment-resistant major depressive disorder.

E. The patient is medically stable and the patient's status and/or co-morbid medical conditions are not contraindications for TMS.

F. All of the following:

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1) there is a clinical contraindication for electroconvulsive therapy (ECT)[14] or the patient refuses ECT: *and*

2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure; *and*

3) the patient can be reasonably expected to comply with post-procedure recommendations.

G. TMS is not considered reasonable and necessary for any of the following (all of the following must be absent)

1) presence of psychotic symptoms in the current depressive episode

2) acute or chronic psychotic disorder such as schizophrenia, schizophreniform disorder, or schizoaffective disorder.

3) neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system.

4) persons with conductive, ferromagnetic or other magnetic-sensitive materials implated in their head which are non-removable and within 30cm of the TMS magnetic coil. Examples include cochlear implants, implanted electrodes/stimulators, aneurysm clips, coils or stents, and bullet fragments.

5) presence of vagus nerve stimulator leads in the carotid sheath.

H. TMS will not be used for maintenance therapy. Maintenance therapy is not currently supported by evidence from clinical trials and therefore is considered not reasonable and necessary.

I . The patient and/or a legal guardian are/is able to understand the purpose, risks and benefits of TMS, and provide(s) consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G, H and I must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is appropriately trained to provide TMS, to include:

1) a psychiatric history, including past response to antidepressant medication(s) and/or TMS and/or ECT, mental status and current functioning; *and*

[14] Studies have demonstrated superior efficacy with ECT in major depression (Eranti, Mogg, Pluck, et al. 2007). ECT should not be delayed in cases where symptoms are life-threatening.

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2) a medical history and examination when clinically indicated.

B. The order for treatment or retreatment is written by a physician (MD or DO) who has examined the patient and reviewed the medical record. The treatment shall be given under direct supervision of this physician, i.e. he or she must be in the area and immediately available. The physician will assess the patient at each treatment, and be present in the area, but not necessarily provide the treatment. The attending physician must monitor and document the patient's clinical progress during treatment. The attending physician must use evidence-based validated depression monitoring scales such as the Geriatric Depression Scale (GDS), the Personal Health Questionnaire Depression Scale (PHQ-9), the Beck Depression Scale (BDI), the Hamilton Rating Scale for Depression (HAM-D), the Montgomery Asberg Depression Rating Scale (MADRS), the Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR), or the Consumer Health Inventory (CHI) to monitor treatment response and the achievement of remission of symptoms.

C. The physician utilizing this technique must have completed a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the Royal College of Physicians and Surgeons of Canada (RCPSC); Board certification in psychiatry by the American Board of Psychiatry and Neurology is preferred. The physician must be privileged by Magellan and/or payer to perform TMS. As a part of privileging, the physician must have completed a university-based course in TMS, or the course approved by the device manufacturer.

D. An attendant/individual trained in basic life support, the management of complications such as seizures, in addition to training in the application of the TMS apparatus, must be present at all times with the patient while the treatment is applied.

E. The attending physician provides personal supervision for the initial motor threshold determinations, treatment parameter definition and TMS treatment course planning and documentation supportive of the level of supervision. The patient has either the attending physician or the attendant physically present at all times during the TMS session.

F. During subsequent delivery and management of TMS sessions the attending physician must meet face to face with the patient when there is a change in the patient's mental status and/ or other significant change in clinical status.

G. Access to emergency equipment, including cardiac defibrillator, and suction is readily available while the patient is receiving TMS.

H. The treatment must be provided by use of a device approved or cleared by the FDA for the purpose of supplying transcranial magnetic stimulation for this indication.

I. When clinically indicated, the patient is released in the care of a responsible adult who can monitor and provide supportive care as needed.

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Criteria for Continued Treatment

III. Continued Treatment

All of the following (IIIA, B, C, D, E, F, and G,) must be met to satisfy the criteria for continued treatment:

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one or more of the following:

B. the persistence of problems that meet the TMS treatment Severity of Need criteria as outlined in I.; *or*

C. the emergence of additional problems that meet the TMS treatment Severity of Need criteria as outlined in I; *or*

D. that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in an exacerbation of the patient's condition and/or status. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

E. TMS is reasonable and necessary for up to 30 visits over a 7 week period, followed by 6 tapered treatments.

F. Retreatment may be considered for patients who met the guidelines for initial treatment and subsequently developed relapse of depressive symptoms if the patient responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms or if there were a relapse after remission [e.g. GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, IDS-SR or CHI.

G. If the patient meets the relapse criteria, up to 30 visits for the acute phase treatment followed by an additional 6 visits for tapering is considered reasonable and necessary.

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Appendix – Outpatient Applied Behavior Analysis

This document is provided as companion to Magellan Healthcare's Medical Necessity Criteria (MNC) for the use of Applied Behavior Analysis (ABA). Magellan supports the use of clinical best practices and strongly encourages participating providers to consult resources such as those published by the Behavior Analyst Certification Board (BACB).

ABA systematically applies interventions based on learning theory to improve social interaction, verbal and nonverbal communication, and maladaptive or challenging behavior while demonstrating that the interventions employed are responsible for the improvement. Deficits in functioning may be due to environmental factors, physical conditions, mental health disorders, and psychological factors. The severity and frequency of maladaptive behavior (e.g., aggression, violence, destructiveness, and self-injury) may result in risk to the physical safety of the individual or others. Applied Behavior Analysis involves the analysis, design, implementation, and evaluation of Behavior modification plans to produce significant improvement in behavior. ABA programs include multiple techniques (e.g., discrete trial training and naturalistic teaching) and integrate different strategies based on the recipient's needs and target goals. ABA methodologies incorporate data collection to monitor the recipient's progress and evaluate the effectiveness of the intervention and evaluate Behavior with validated tools and objective developmental norms. An ABA program is directed to promoting the greatest level of independence possible for the recipient and provides training and support for the caregivers. An ABA program that does not include the substantial involvement of the recipient's caregivers does not meet Magellan's expectations of a successful treatment plan based on an extensive review of the available literature on the effectiveness of ABA and as such, cannot be authorized for reimbursement.

Essential Elements of Effective ABA Treatment

1. An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection and the use of validated assessment tools and developmental norms.
2. An understanding of the context of the behavior and the behavior's value to the individual, the family, and the community and a plan to address the most socially significant deficits in skill or problem behaviors that will allow the independent functioning for the recipient across these environments.
3. A through review of the recipient's medical, educational, and psychological and behavioral history and ongoing coordination of care with other providers involved in the recipient's treatment (e.g. physical therapists, social workers, occupational therapists, pediatricians, speech therapists).
4. The use of ongoing, objective assessments and data analysis to inform clinical decision- making.

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5. A focus on the recipient's quality of life, with care provided only for as long as necessary to achieve goals, or maximize clinical benefit, and promote independence for the recipient.
6. The facilitation of opportunities for the recipient to interact with typically developing peers.
7. The inclusion of the recipients" caregivers in a formalized program of training that allows them to develop skills and apply these in naturalized settings to further the recipient's treatment goals.
8. A strong program of support for the caregivers that addresses the stresses and strains of care giving including community connection to supportive resources.

Initial Evaluation

After an initial diagnosis of autism has been obtained from an appropriate provider (e.g. pediatrician, pediatric neurologist, developmental pediatrician, psychologist), a Functional Behavioral Assessment should be completed that includes observation across all relevant settings (e.g. home, school and community). The intent of the FBA is to develop a through plan of interventions that will target reductions in problematic behaviors, in addition to the promotion of more adaptive skills and behaviors. The FBA capture baseline data and will design a plan of ongoing data collection that will inform the duration and intensity of services. The FBA will include a plan for the training of the recipient's caregivers, complete with goals for the caregivers and a plan to train and support the caregivers. The FBA should include:

1. Validated developmental and adaptive skills assessment (e.g. ABAS, Vineland, DAYC, Bayley, Mullens, VB-MAPP or ABLLS) to establish baseline functioning.
2. Review of the recipients' medical, psychiatric, educational records.
3. An evaluation of the purpose of maladaptive behaviors using a validated assessment tool (e.g. QABF, FAST, FACT).
4. Caregiver Interview.
5. Evidence of coordination of services with the recipient's other treatment providers.
6. Consideration for the recipient's medications and medical co-morbidities.
7. A detailed description of behavior reduction goals with clear definition, antecedent, baseline, and mastery criteria for needed skills development.
8. A detailed description of replacement behavior and skill acquisition goal section based on reported behaviors and developmental evaluation scores.
9. Caregiver training goals and a plan to provide necessary support and training to caregivers as well as a plan to evaluate their acquisition of these skills.
10. A detailed proposal for the intensity and duration of services, as well as the locations where those services will be provided.
11. Full documentation of any IEP services the recipient is receiving and a description of how the proposed care will coordinate with the established IEP.
12. An indication of other services which will be necessary such as physical therapy or family therapy and documentation that such referrals have been provided.

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13. A clear plan with objective milestones for the systematic reduction of care and the criteria for discharge from services.

Ongoing Services

1. Validated developmental and adaptive skills assessment (e.g. ABAS, Vineland, DAYC, Bayley, Mullens, VB-MAPP or ABLLS) should be administered every 3 months to evaluate progress from baseline functioning.
2. Care should be applied as prescribed in the treatment plan and Behavior tracking should be completed such that the occurrence and frequency of maladaptive behaviors as well as replacement behaviors are captured graphically.
3. Antecedents to behavior should be noted and well as response to interventions.
4. The setting of ongoing services should be captured as well as participants present during the intervention.
5. Interventions should promote the recipient's independence and should be focused on those behaviors that interfere with the recipient's self care abilities, the recipient's safety and those behaviors with interfere with the recipient's communication and interaction with others.
6. Caregivers should be present during all interventions and should receive training on the intervention such that the treating professional can fade out of the intervention and the caregiver can effectively achieve the goal of the intervention over time.
7. Caregivers should have specific Behavior goals that generalize treatment benefits across multiple settings and allow treatment progress to be maintained over time.
8. The recipient should be presented with opportunities to demonstrate skills acquisition with developmentally typical peers.
9. Adjustments to treatment interventions will be made in consultation with the BCBA supervisor and the reason for these adjustments will be well documented in the clinical record, including the goals and the Behavior tracking of these goals.
10. A detailed tracking of the intensity of services as well as the locations where those services are provided shall be maintained in the treatment record.
11. Coordination with other services such as physical therapy or family therapy should be ongoing.
12. Measurement of progression on milestones should be captured on an ongoing basis and progress to discharge goals should be noted.

Intensity of Services

The intensity and duration of services will be based on a careful evaluation of the level of the recipient's impairment from developmentally expected norms as well as the severity of maladaptive behaviors. Behaviors and skills deficits that prevent the recipient from performing activities of daily living related to self care (e.g. self feeding, toileting and grooming), socially effective communication (e.g. mutuality, emotional reciprocity, stereotypy, shared interests) or safety (e.g. aggression, pica, elopement).

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The use of standardized testing is critical in the evaluation of the recipient's development against published developmental norms. Scores less than a standard deviation from developmental norms are considered within range of normal development, 1 standard deviation equates to mild impairment, 1.5-2 standard deviations equates to moderate impairment and 2 or more standard deviations will be considered severe. The response to services must be evaluated on an ongoing basis with validated tools to monitor treatment progress. Treatment progress should also be evaluated against treatment goals through careful tracking of the frequency of maladaptive behaviors as well as replacement behaviors. The achievement of caregiver goals should be consistently tracked. Lack of skills acquisitions or behavioral goals require immediate attention to required changes in the intervention and may lead to the discontinuation of services.

Comprehensive Interventions:

- Comprehensive services generally are be restricted to younger children who have substantial impairments in most or all areas of functioning; behavior is of such a severe nature that the child or those around the child are in imminent risk of harm; and are generally authorized as time limited
- The overarching goal of comprehensive intervention is to close the gap between a recipient's level of functioning and that of a typically developing peer.
- Comprehensive ABA of up to 40 hours per week is limited to treatment where there are multiple targets across most or all developmental domains that are impaired due to the child's autism.
- Comprehensive services are generally rendered when the recipient is early in his or her development and is generally not intended to be applied to older children or adolescents who are often more appropriate for focused interventions
- Optimal treatment duration will vary by child, but literature generally supports total interventions (focused and comprehensive) up to of 1-2 years of care.

Focused Interventions:

- Magellan will authorize medically necessary applied Behavior analysis, based on individualized goals, provided in a focused or comprehensive manner:
    - Focused interventions are generally authorized for 10-25 hours per week of direct treatment (additional authorization will be provided for direct and indirect supervision at 1 to 2 hours per 10 of direct care, as well as authorization for caregiver training).
    - Focused intervention is authorized when the recipient needs to acquire skills such as communication, safety and self care.
    - Focused intervention is authorized to reduce dangerous or maladaptive behavior.
    - Focused intervention is authorized to introduce and strengthen more appropriate and functional behavior.

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- Magellan encourages providers to consult with a Magellan Care Manager if there are questions about the appropriateness of a planned intervention and any time a child's condition worsens for any reason.