



CIGNA MEDICAL NECESSITY CRITERIA

for Treatment of Behavioral
Health and Substance Use Disorders

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Foreword

Over the last few years, with the passage of The Federal Mental Health Parity and Addiction Equity Act in 2008 and The Patient Protection and Affordable Care Act in 2010, the healthcare industry has evolved and increased in complexity. There is increased benefit coverage for people with mental health and substance use conditions, and these new laws have changed the way healthcare coverage is managed. This has addressed some of the barriers that individuals have faced in obtaining the proper diagnosis and essential treatment for their condition, such as the lack of health insurance coverage and the personal cost in accessing treatment. However, we continue to be faced with a shortage of mental health services and clinicians in many areas of the country. And despite Americans having a more sophisticated understanding of mental illness, along with an increased awareness through exposure on television and in the media, studies continue to show that there is persistent social stigma attached to people with mental illness and substance use disorders.

With 170 million Americans covered under employer-based Insurance today, and with almost 200 million having some sort of private health insurance, it is essential that we work together to renew our focus and take advantage of the advances brought by these new regulations. We also need to turn our remaining challenges into opportunities. Ultimately, we all share the desire to see every individual get the best care that can be provided. In doing so, we have the responsibility to collaborate with each other to leverage each individual's health care benefits and to deliver the most effective care in the most appropriate setting at the right time.

Several key focus areas are necessary to consider as we engage in a cooperative and inclusive dialogue. They include variations in standards of care across the country and health care disparities for people with mental health diagnoses. There are still significant gaps in service between mental health clinicians and general medical clinicians. This is important not only as we attempt to provide an integrated and holistic health care experience for individuals, but especially since the majority of people with mental health symptoms are currently only treated by primary care physicians.

With all of the complexity in health care, we support practitioners in exercising their professional judgment to make informed decisions and offer quality care. We also support a consistent application of evidence-based guidelines to enhance clinical judgment and to ensure that treatment includes consideration of the practices that have been shown to be most effective for each individual's condition. In keeping with this commitment, we have developed our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders. These Criteria are intended to be a working document to help set expectations and facilitate a shared responsibility. These Criteria do not replace clinical judgment, and we recognize that these Criteria require adaptation to the unique situations of each individual patient.

We hope this document will prove to be a worthwhile resource, and we thank our practitioners for the outstanding work they do in helping individuals to live healthier, more balanced lives. At Cigna, we support open dialogue with our clinician community and all of our customers, and we welcome ongoing feedback to find ways that we can all work together to better serve you.



Douglas Nemecek, M.D., M.B.A.

Chief Medical Officer – Behavioral Health

Core Principles

General Overview

Cigna is committed to helping the people we serve improve their health, well-being, and sense of security. That is our mission. We realize that this is not possible without the understanding that mental health is equally important to physical health. There is a growing awareness across the United States of the influence of mental health and substance use conditions and the burden they place on individuals, families, and society. We believe that effective treatment for any illness must address mental health and physical health together. In fact, effective mental health and substance use disorder treatment is a cornerstone to driving holistic health and well-being. Taking this holistic view, with our focus on mental health and substance use issues, helps the people we serve be more productive at work, and more importantly, more productive at home with their families and in their communities.

At Cigna, we strongly believe that the core principle that guides behavioral health care is that access to high quality care should be assured for everyone. This is true regardless of the diagnosis, treatment setting, type of clinician, geographic location, or the gender, ethnicity, or socioeconomic background of the individual seeking care. According to the 2005 Institute of Medicine report, “Improving the Quality of Health Care for Mental and Substance-Use Conditions,” there are six dimensions that need to be addressed in achieving high quality care for patients.¹ Quality mental health care needs to be: safe, effective, patient-centered, timely, efficient, and equitable. Acceptance of these six dimensions of care is essential to delivering the most effective and most appropriate care to every patient. This Institute of Medicine report also identifies the importance of patient care being coordinated across people, functions, activities, and treatment settings over time so that each patient receives the maximum benefit from their treatment services. It is from this core principle that Cigna has developed our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders.

Medical Necessity Criteria

Cigna begins with evidence-based guidelines as the basic platform to define established standards of effective care. Scientific evidence is the vital element in the development of an informed decision-making process for patients and their clinicians. Over the last 10 years, the Surgeon General², the President’s New Freedom Commission on Mental Health³, and the Institute of Medicine¹ have all produced reports that highlight the importance of improving the dissemination and adoption of evidence-based practices. Effective treatment is ultimately linked to the consistent use of these evidence-based clinical practices and the ability of mental health clinicians to effectively execute these therapies.

Cigna has adopted nationally developed and published guidelines of the American Psychiatric Association, the American Association of Pediatrics and the National Institute on Alcohol Abuse and Alcoholism due to their acceptance as the best of evidence-based practice for mental health and substance use disorders. Our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders then serve as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. We have chosen not to adopt private, proprietary level of care guidelines from companies such as McKesson Health Solutions or Milliman, but to develop and implement our own. This decision strongly reflects our philosophy that Cigna’s Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders should reflect the mutual consensus of all of our stakeholders, be transparent and available to everyone, and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

In the development of our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders, Cigna has listened to the messages and feedback from patients, advocacy groups (MHA and NAMI), professional associations (American Psychiatric Association,

American Psychological Association, NASW, AAMFT, and ASAM), psychiatrists, psychologists, and therapists across the country. We have attempted to incorporate the strongest, evidence-based points into our Criteria. These Criteria then become a working document to help set expectations and to facilitate a joint working relationship and shared responsibility between Cigna and mental health and substance use disorder clinicians.

Cigna is proud to keep the development process of our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders open and transparent to the public. We appreciate the active and meaningful role that patients, clinicians, and advocates have in determining how the scientific evidence is applied in our Criteria. In addition to listening to their input, we have also worked to write our Criteria in words that everyone can understand. Our Criteria are only of value when we can have open, clear, and complete discussions, and when both individuals and their clinicians can understand and use the Criteria in their behavioral healthcare decision making.

Cigna believes that all treatment decisions that are made in alignment with these Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders must be first and foremost clinically based. Care must be patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual. In this way, the Criteria promote advocacy for the patient and enhance the collaboration between Cigna and clinicians to achieve optimal, patient-centered outcomes. They also promote consistent communication and coordination of care from one treatment setting to the next.

Providing every individual with access to quality, evidence-based, patient-centered care is the core tenet of our philosophy at Cigna. It is from this philosophy that our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders help drive improvements in holistic health care and ensure consistent, meaningful outcomes for everyone.

Douglas Nemecek, M.D., M.B.A.

Chief Medical Officer – Behavioral Health

¹*Improving the Quality of Health Care for Mental and Substance Use Conditions. Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board of Health Care Services. Washington DC: National Academies Press, 2005.*

²*Mental Health: A Report of the Surgeon General. Office of the Surgeon General. Public Health Service, Department of Health and Human Services. Washington DC, 1999.*

³*Achieving the Promise: Transforming Mental Health Care in America. The President's New Freedom Commission on Mental Health, Department of Health and Human Services. Washington DC, 2003.*



Section

1

**MENTAL HEALTH
TREATMENT FOR ADULTS**



Acute Inpatient Mental Health Treatment for Adults

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Acute Mental Health Treatment for Adults is utilized when the following services are needed:

- Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring
- Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others,
- Daily monitoring of psychiatric medication effects and side effects, and
- A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Mental Health Treatment for Adults:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician, with experience in acute psychiatric emergencies, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Acute psychiatric hospitalization may be a consideration when appropriate alternative less restrictive levels of care are unavailable.

Expectations for Acute Mental Health Treatment for Adults:

- A thorough Psychiatric Evaluation is completed within 24-hours of admission.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist.
- Psychiatric follow-up occurs daily or more frequently as needed.
- A medical workup is completed as needed or appropriate.
- Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
- The facility must be able to rapidly assess and address any urgent behavioral and/or physical issues

An Individualized Treatment Plan is completed within 24-hours of admission. This plan includes:

- A focus on the issues leading to the admission.
- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.

- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

– **Planning for Discharge**

A Discharge Plan that starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. It is very likely that the individual is about to cause serious bodily harm to him/herself or someone else due to a psychiatric illness other than Antisocial Personality Disorder, as evidenced by:
 1. A recent and serious suicide attempt or threat to others involving deadly intent or plan, OR

2. A current expression of suicidal intent or homicidal intent (or a plan for bodily harm that has a high possibility of becoming deadly or causing serious injury), OR
3. Recent, serious and intentional self injury along with an inability to develop a reasonable plan for safety so that 24-hour observation, safety measures, and treatment are needed in a secure setting, OR
4. Recent violent, impulsive and unpredictable behavior that is likely to result in harm to the individual or someone else without 24-hour observation and treatment, including the possible use of seclusion and/or restraints in a secured setting. OR

B. It is very likely that serious harm will come to the individual due to a psychiatric illness, and that harm cannot be prevented at a lower level of care as evidenced by:

1. The individual is unable to care for self (nutrition, shelter, and other essential activities of daily living) due to his/her psychiatric condition so that life-threatening deterioration is expected, OR
2. The individual has irrational or bizarre thinking, and/or severe slowness or agitation in movements along with interference with activities of daily living of such severity as to require 24-hour skilled psychiatric/medical, nursing and social service interventions OR

C. The individual has a secondary condition such that treatment cannot be provided at a less restrictive level of care as evidenced by:

1. A life threatening complication of an eating disorder, OR
2. A complicated general medical condition (i.e., cardiac disease, pregnancy, diabetes) which requires that psychiatric interventions be monitored in a 24-hour psychiatric/medical setting, OR
3. The individual requires ECT (Electroconvulsive Therapy) and the initial trial requires a 24-hour psychiatric/medical setting. OR

D. Appropriate less restrictive levels of care are unavailable for safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**

- A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and modification to the treatment plan when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Residential Mental Health Treatment for Adults

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Residential Mental Health Treatment for Adults:

- A licensed mental health facility with 7 day a week, 24-hour around-the-clock supervision on a unit that is not locked.
- Residential Treatment Programs are made up by a multidisciplinary team led by a board certified/eligible psychiatrist.
- A nurse or psychiatrist is on site 24/7 to assist with medical issues/crisis intervention and medication administration as needed.
- Treatment is focused on improving functioning rather than primarily for the purpose of maintenance of the long-term gains made in an earlier program.
- There are a variety of residential settings that are not medically necessary treatment programs.
For example:
 - Group Homes
 - Other Supportive Housing
 - Most Wilderness Programs
- Residential treatment coverage is not based on a preset number of days. A standardized program such as a "30-Day Treatment Program" is not considered as a medically necessary reason for admission or continued stay at this level of care.
- Residential treatment is a transitional, structured environment that will allow the individual to successfully reintegrate into a community-based living arrangement. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community.

Admission Considerations for Residential Mental Health Treatment for Adults:

- Prior to admission, there has been a face-to-face assessment with the individual and family (when appropriate), to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Mental Health Residential Treatment may be authorized when appropriate alternative levels of care are unavailable.

Expectations for Residential Mental Health Treatment for Adults:

- Residential treatment should occur as close as possible to the home to which the individual will be discharged. If out-of-area placement is unavoidable, and family is available, there must be a family session and facility commitment to assure regular indicated family therapy as well as needed familial contact with the individual and facility.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The treatment plan includes realistic and achievable treatment goals, and a discharge plan with specific timelines for expected implementation and completion.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a face-to-face setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

A Discharge Plan that starts at the time of admission that includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care

- Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
- Continuation in this level of care because alternative placement is not available is not justification for continued authorization to the residential treatment facility.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The individual has been diagnosed with a severe psychiatric disorder that is pervasive and significantly impairs functioning. This impairment in function is seen across multiple settings such as work, home, and in the community, and clearly demonstrates a need for 24-hour supervision and active treatment, OR
 - B. Immediate prior treatment in a more intensive level of care (such as mental health inpatient) has resulted in an acceptable degree of stability. However, the individual continues to display behaviors that require around-the-clock supervision in a structured setting in order to maintain the safety of the individual and others.
3. **All of the following criteria must be met:**
 - A. The individual demonstrates chronic dysfunction, which is likely to respond to multiple therapeutic and family treatment interventions, and the individual and family commit to active regular treatment participation
 - B. The individual is able to function with some independence, participate in structured activities in a group environment, and is capable of developing the skills necessary for functioning outside of the residential program.
 - C. Less restrictive or intensive levels of treatment are not appropriate to meet the individual's needs or have been tried and were unsuccessful.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression

towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

- B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
- 3. **All of the following must be met:**
- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- F. Continued stay is not primarily due to a lack of external supports.

Partial Hospitalization Mental Health Treatment for Adults

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Partial Hospitalization Mental Health Treatment for Adults

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for individuals who can be maintained safely in the community at a minimal level of functioning if closely monitored. This level of care should be considered for individuals:

- Who are having significant acute difficulties with daily functioning at work, parenting, and/or with other activities of daily living. Treatment provided in this setting is essentially the same in nature and intensity as is provided in an inpatient hospital setting. As such the role of this level of care is to respond to acute situations, which absent of this level of care would potentially result into life-threatening emergencies.
- Who may present ongoing risk of harm to him/herself or others, but is able to develop a plan to maintain safety in the community without 24-hour supervision.

Note: *This level of care should not be confused with the sub-acute “Day Programs” where the focus is on more long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.*

Admission Considerations for Partial Hospitalization Mental Health Treatment for Adults:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician with experience in acute psychiatric emergencies, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Psychiatric Partial hospitalization may be authorized when appropriate alternative less restrictive levels of care are unavailable. This level of care can also be the initial level of care authorized.

Expectations for Partial Hospitalization Mental Health Treatment for Adults:

- Individuals who are at this level of care:
 - Are typically in a structured treatment program 5-6 hours per day, 5 days per week.
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
 - Live in the community without the restrictions of a 24-hour supervised setting

- Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
- The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist
- This level of care is used as a time-limited level of intervention to stabilize acute symptoms, facilitating a transition to lower levels of care when clinically indicated.
- Individuals and/or their supports are capable of accessing emergency services.

An Individualized Treatment Plan is completed within 24-hours of admission. This plan includes:

- A focus on the issues leading to the admission.
- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **The Treatment Plan is not based on a pre-established programmed plan or time frames.**

Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

– **Planning for Discharge**

A Discharge Plan that starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following must be met:**
 - A. The individual has recently threatened to harm her/himself or others or has had recurrent thoughts to harm self or others to an extent that he/she requires the daily structure and monitoring of a partial hospital but does not require a 24-hour monitoring environment, OR
 - B. The individual has recently demonstrated actions of serious physical aggression to self or others or severe property destruction with a likely potential for similar repeated actions/behaviors, but does not require a 24-hour monitoring environment, OR
 - C. Due to a worsening of psychiatric symptoms, there is a high likelihood that the individual will require inpatient admission in the near future if not in a partial hospital program, OR
 - D. The individual has such irrational or bizarre thinking or a severe slowness or agitation in movements due to a psychiatric condition such that it interferes with activities of daily living or abilities to fulfill family and/or occupational roles, but not requiring 24-hour monitoring. In addition, the impairment is so severe that a structured intensive treatment program is necessary and safe, effective treatment cannot be provided at a less intensive level of care.
3. **There is evidence of all of the following:**
 - E. The individual has the capacity for reliable attendance and active participation in the treatment plan.
 - F. The risk of harm to self, others, or property has been assessed by a mental health professional as being due to a psychiatric illness other than antisocial personality disorder and not requiring a more intensive level of care.

- G. The individual is capable of developing a safety plan for when not at the partial hospital and seeking emergency assistance if safety risks increase.
- H. The individual has support systems available to assist them when not at the partial hospital program if necessary.
- I. Less restrictive or intensive levels of treatment are not appropriate to meet the individual's needs or have been tried and were unsuccessful.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Mental Health Treatment for Adults

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Intensive Outpatient Mental Health Treatment for Adults

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for an individual who can maintain some ability to fulfill family, student, or work activities.

- The severity of psychosocial stressors and often complex family dysfunction are such that the multi disciplinary treatment plan developed at this level of care is necessary to stabilize the individual.
- Despite these stressors, the individual is not at imminent risk for serious bodily injury due to aggression toward self or others.
- Intensive Outpatient Mental Health Treatment is appropriate to consider for complex or refractory clinical situations that would otherwise result in the need for a more restrictive level of care. The duration of treatment and frequency of attendance are continually evaluated and adjusted according to the individual severity of signs and symptoms. Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- This level of care can be the first level of care authorized, to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant returned to a less structured outpatient setting.

Notes:

- *This level of care should not be confused with the sub-acute "Day Programs" where the focus is on more long-term social*

rehabilitation and maintenance of individuals with severe and persistent mental illness.

- **Low Intensity Outpatient Programs and Aftercare Services** are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Behavioral Health Treatment.

Admission Considerations for Intensive Outpatient Mental Health Treatment for Adults:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Intensive Outpatient Program may be authorized when alternative levels of care that may be appropriate are unavailable.

Expectations for Psychiatric Intensive Outpatient Treatment for Adults (Mental Health):

- Individuals who are at this level of care:
 - Are typically in a structured treatment program 2-3 hours per day, 3-5 days per week.
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
 - Live in the community without the restrictions of a 24-hour supervised setting
 - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.

- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
- Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)
 - **Planning for Discharge**
- A **Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The individual's function has deteriorated to such a degree that s/he is experiencing difficulty in ability to perform family, school, or work activities. In addition, the impairment is at a level that cannot be addressed in routine outpatient therapy and structured intervention is required to prevent the need for a more intensive level of care, OR
 - B. The individual, while intermittently experiencing thoughts of harm to self or others, is able to develop a safety plan including being able to access emergency services and is

considered at low-risk so that a more intensive level of care is not required, OR

- C. The individual has demonstrated a lack of improvement or deterioration in functioning while in outpatient treatment such that the interventions of a multi-disciplinary team are needed to stabilize the individual and prevent a more intensive level of care, OR
- D. The individual's past history indicates that when similar clinical circumstances occurred, intensive outpatient treatment was sufficient to prevent clinical deterioration or avert the need for a more intensive level of care.

Criteria for Continued Stay

All of the following must be met:

- 1. The individual continues to meet all basic elements of medical necessity.
- 2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
- 3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.



Section

2

**MENTAL HEALTH TREATMENT
FOR CHILDREN AND
ADOLESCENTS**



Acute Inpatient Mental Health Treatment for Children and Adolescents

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Acute Inpatient Mental Health Treatment for Children and Adolescents is

utilized when the following services are needed:

- Around-the-clock intensive psychiatric/medical and nursing care, including continuous observation and monitoring.
- Acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others.
- Daily monitoring of psychiatric medication effects and side effects and

- A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Mental Health Treatment for Children and Adolescents:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician, with experience in acute psychiatric emergencies, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Acute psychiatric hospitalization may be a consideration when appropriate alternative less restrictive levels of care are unavailable

Expectations for Acute Inpatient Mental Health Treatment for Children and Adolescents:

- A thorough Psychiatric Evaluation is completed within 24-hours of admission
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified Child Psychiatrist.
- Psychiatric follow-up occurs daily or more frequently as needed.
- A medical work-up is completed as needed or appropriate.
- Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
- Young children (12 years and younger) will be admitted to a unit exclusively for children.
- Ongoing academic schooling is provided to facilitate a transition back to the child’s previous school setting.

- The facility must be able to rapidly assess and address any urgent behavioral and/or physical issues.

An Individualized Treatment Plan is completed within 24-hours of admission. This plan includes:

- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Planning for Discharge** starting at the time of admission

• **A Discharge Plan** that includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. One or more of the following criteria must be met:
 - A. It is very likely that the child/adolescent is about to cause serious bodily harm to him/herself or someone else due to a psychiatric illness as evidenced by:
 1. A recent and serious suicide attempt or threat to others involving deadly intent or plan, OR
 2. A current expression of suicidal intent or homicidal intent (or a plan for bodily harm that has a high possibility of becoming deadly or causing serious injury), OR
 3. Recent, serious and intentional self injury along with an inability to develop a reasonable plan for safety so that 24-hour observation, safety measures, and treatment are needed in a secure setting, OR
 4. Recent violent, impulsive and unpredictable behavior that is likely to result in harm to the individual or someone else without 24-hour observation and treatment, including the possible use of seclusion and/or restraints in a secured setting.
 - B. It is very likely that serious harm will come to the child/adolescent due to a psychiatric illness, and that harm cannot be prevented at a lower level of care as evidenced by:
 1. The child/adolescent is unable to care for self (nutrition, shelter, and other essential activities of daily living) due to his/her psychiatric condition so that life-threatening deterioration is expected, OR
 2. The child/adolescent has irrational or bizarre thinking, and/or severe slowness or agitation in movements along with interference with activities of daily living of such severity as to require 24-hour skilled psychiatric/medical, nursing and social service interventions.
 - C. The child/adolescent has a secondary condition such that treatment cannot be provided at a less restrictive level of care as evidenced by:
 1. A life threatening complication of an eating disorder, OR
 2. A complicated general medical condition (i.e., cardiac disease, pregnancy, diabetes) which requires that psychiatric interventions be monitored in a 24-hour psychiatric/medical setting, OR
 3. The child/adolescent requires ECT (Electroconvulsive Therapy) and the initial trial requires a 24-hour psychiatric/medical setting,
 - D. Less restrictive levels of care are unavailable for safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Residential Mental Health Treatment for Children and Adolescents

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Residential Mental Health Treatment for Children and Adolescents:

- A licensed mental health facility with 7 day a week, 24-hour around-the-clock supervision on a unit that is not locked.



- Residential Treatment Programs are made up by a multidisciplinary team led by a board certified/eligible child/adolescent psychiatrist.
- A nurse or psychiatrist is on site 24/7 to assist with medical issues/crisis intervention and medication administration as needed.
- Treatment is focused on improving functioning rather than primarily for the purpose of maintenance of the long-term gains made in an earlier program.
- There are a variety of residential settings that are not medically necessary treatment programs. For example:
 - Group Homes
 - Other Supportive Housing
 - Therapeutic schools
 - Most Wilderness Programs.
- Residential treatment coverage is not based on a preset number of days. A standardized program such as a “30-Day Treatment Program” is not considered as a medically necessary reason for admission or continued stay at this level of care.
- Residential treatment is a transitional, structured environment that will allow the individual to successfully reintegrate into a community-based living arrangement. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community.

Admission Considerations for Residential Mental Health Treatment for Children and Adolescents:

- Prior to admission there has been a face-to-face assessment with the child/adolescent and family to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate
- Mental Health Residential treatment may be authorized when appropriate alternative less restrictive levels of care are unavailable

Expectations for Residential Mental Health Treatment for Children and Adolescents:

- Residential treatment should occur as close as possible to the home to which the individual will be discharged. If out-of-area placement is unavoidable, and family is available, there must be a family session and facility commitment to assure

regular indicated family therapy as well as needed familial contact with the individual and facility.

- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The treatment plan includes realistic and achievable treatment goals, and a discharge plan with specific timelines for expected implementation and completion.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **A Discharge Plan** that starts at the time of admission that includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

- Continuation in this level of care because alternative placement is not available is not justification for continued authorization to the residential treatment facility.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The child/adolescent has been diagnosed with a severe psychiatric disorder that is pervasive and significantly impairs developmentally appropriate functioning. This impairment in function is seen across multiple settings such as; school, home, and in the community, and clearly demonstrates a need for 24-hour supervision and active treatment, OR
 - B. Immediate prior treatment in a more intensive level of care (such as mental health inpatient) has resulted in an acceptable degree of stability. However, the child/adolescent continues to display behaviors that require around-the-clock supervision in a structured setting in order to maintain the safety of the child/adolescent and others.
3. **All of the following criteria must be met:**
 - C. The child/adolescent and/or family demonstrate chronic dysfunction, which is likely to respond to multiple therapeutic and family treatment interventions, and all parties commit to active regular treatment participation.
 - D. The child/adolescent is able to function with age-appropriate independence, participate in structured activities in a group environment, and is capable of developing the skills necessary for functioning outside of the residential program.
 - E. Less restrictive or intensive levels of treatment are not appropriate to meet the individual's needs or have been tried and were unsuccessful.

Criteria for Continued Stay

All of the following must be met:

1. **The individual continues to meet all basic elements of medical necessity.**
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can

be safely and effectively treated at a less restrictive level of care, OR

- B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Partial Hospitalization Mental Health Treatment for Children and Adolescents

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Partial Hospitalization Mental Health Treatment for Children and Adolescents

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for individuals who can be maintained safely in the community at a minimal level of functioning if closely monitored. This level of care should be considered for individuals:

- Who are having significant acute difficulties with daily functioning at school, with family, and peers, or with other activities of daily living. Treatment provided in this setting is essentially the same in nature and intensity as is provided in an inpatient hospital setting. As such the role of this level of care is to respond to acute situations, which absent of this level of care would potentially result into life-threatening emergencies.
- Who may present ongoing risk of harm to him/herself or others, but is able to develop a plan to maintain safety in the community without 24-hour supervision.

Note: This level of care should not be confused with the sub-acute “Day Programs” where the focus is on more long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.

Admission Considerations for Partial Hospitalization Mental Health Treatment for Children and Adolescents:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician with experience in acute psychiatric emergencies to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Psychiatric Partial hospitalization may be authorized when appropriate alternative less restrictive levels of care are unavailable.



Expectations for Partial Hospitalization Mental Health Treatment for Children and Adolescents

- Individuals in this level of care:
 - Are typically in a structured treatment program 5-6 hours per day, 5 days per week.
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
- Live in the community without the restrictions of a 24-hour supervised setting
- Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
- The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist

- This level of care is used as a time-limited level of intervention to stabilize acute symptoms, facilitating a transition to lower levels of care when clinically indicated.
 - This level of care can also be the initial level of care authorized.
 - The child/adolescent and/or their supports are capable of accessing emergency services.
 - Academic needs of the child/adolescent need to be addressed while in a partial level of care.
- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

An Individualized Treatment Plan is completed within 24-hours of admission. This plan includes:

- A focus on the issues leading to the admission.
- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **The Treatment Plan is not based on a pre-established programmed plan or time frames.**

Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The child/adolescent has recently threatened to harm her/himself or others or has had recurrent thoughts to harm self or others to an extent that he/she requires the daily structure and monitoring of a partial hospital but does not require a 24-hour monitoring environment, OR
 - B. The child/adolescent has recently demonstrated actions of serious physical aggression to self or others or severe property destruction with a likely potential for similar repeated actions/behaviors, but does not require a 24-hour monitoring environment, OR
 - C. Due to a worsening of psychiatric symptoms, there is a high likelihood that the child/adolescent will require inpatient admission in the near future if not in a partial hospital program, OR
 - D. The child/adolescent has such irrational or bizarre thinking or a severe slowness or agitation in movements due to a psychiatric condition such that it interferes with activities of daily living or abilities to fulfill family and/or student roles, but not requiring 24-hour monitoring. In addition, the impairment is so severe that a structured intensive treatment program is necessary and safe, effective treatment cannot be provided at a less intensive level of care.
3. **There is evidence of all of the following:**
 - E. The child/adolescent is capable of regular attendance and active participation in their treatment plan.
 - F. The risk of harm to self, others, or property destruction has been assessed by a mental health professional as being due to a psychiatric illness and not requiring a more intensive level of care.
 - G. The child/adolescent and/or family are capable of developing a safety plan for when not at the partial program hospital and seeking emergency assistance if safety risks increase.

- H. The child/adolescent has reliable support systems available to assist them when not at the partial hospital program.
- I. Less restrictive or intensive levels of treatment are not appropriate to meet the individual's needs or have been tried and were unsuccessful.

Criteria for Continued Stay

All of the following must be met:

1. The child/adolescent continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the child/adolescent is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The child/adolescent has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Mental Health Treatment for Children and Adolescents

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment,

would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description - Intensive Outpatient Mental Health Treatment for Children and Adolescents

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for an individual who can maintain some ability to fulfill family, student, or work activities.

- The severity of psychosocial stressors and often-complex family dysfunction are such that the multi-disciplinary treatment plan developed at this level of care is necessary to stabilize the individual.



- Despite these stressors, the individual is not at imminent risk for serious bodily injury due to aggression toward self or others.
- IOP is appropriate to consider for complex or refractory clinical situations that would otherwise result in the need for a more restrictive level of care. The duration of treatment and frequency of attendance are continually evaluated and adjusted according to the individual severity of signs and symptoms. Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- This level of care can be the first level of care authorized, to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant returned to a less structured outpatient setting.

Notes:

- *This level of care should not be confused with the sub-acute "Day Programs" where the focus is on more long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.*
- **Low Intensity Outpatient Programs and Aftercare Services** are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Behavioral Health Treatment.

Admission Considerations for Intensive Outpatient Mental Health Treatment for Children and Adolescents:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Intensive Outpatient Program may be authorized when alternative levels of care that may be appropriate are unavailable.

Expectations of Intensive Outpatient Mental Health Treatment for Children and Adolescents:

- Individuals who are at this level of care:
 - Are typically in a structured treatment program 2-3 hours per day, 3-5 days per week.

- Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
- Live in the community without the restrictions of a 24-hour supervised setting
- Are capable of safely controlling their behavior and seeking professional assistance or other support as needed
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
- Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)
 - **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.

- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

Note:

All of the following must be met:

1. All basic elements of Medical Necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The child/adolescent's function has deteriorated to such a degree that he/she is experiencing difficulty in ability to perform family, school, work activities. In addition, the impairment is at a level that cannot be addressed in routine outpatient therapy and structured intervention is required to prevent the need for a more intensive level of care, OR
 - B. The child/adolescent, while intermittently experiencing thoughts of harm to self or others, is able to develop a safety plan with the provider that includes being able to access emergency services and is considered at low-risk so that a more intensive level of care is not required, OR
 - C. The child/adolescent has demonstrated a lack of improvement or deterioration in functioning while in outpatient treatment such that the interventions of a multi-disciplinary team are needed to stabilize him/her and prevent a more intensive level of care, OR
 - D. The child/adolescent's past history indicates that when similar clinical circumstances occurred, intensive outpatient treatment was sufficient to prevent clinical deterioration or avert the need for a more intensive level of care.

Criteria for Continued Stay

All of the following must be met:

1. The child/adolescent continues to meet all basic elements of medical necessity,
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and,

modification to the treatment plan, when clinically indicated, OR

- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.





Section

3

OUTPATIENT TREATMENT



Outpatient Behavioral Health Treatment

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Outpatient Behavioral Health Treatment has the following focus and goals:

- Reduce or alleviate the individual’s symptoms
- Return individual to baseline or improve the level of functioning and/or
- Prevent imminent deterioration that would lead to a need for admission to a more intensive level of care.

Outpatient Behavioral Health Treatment may consist of Individual Therapy, Group Therapy, Family Therapy, Medication Management, or any combination of these four types of treatment.

Individual Therapy – This is a process in which an individual is involved in a therapeutic setting with a mental health or substance abuse clinician on an individual basis. Individual therapy should be considered when:

- The individual is experiencing symptoms or impairments that are impacting their day to day functioning, relationships, work or school performance.
- The individual has been unable to alleviate their symptoms on their own and/or is in need of additional assistance to relieve their symptoms.

Group Therapy – This is a process in which a number of people are involved in a therapeutic setting at the same time under the guidance of a mental health or substance abuse clinician. Groups focus on an individual within the context of a group, on interactions that occur among individuals in the group, or on the group as a whole. Group therapy may be considered when:

- Problems are best treated in a social context,
- Peer group interaction will enhance the effectiveness of problem solving,
- Creating bonds or learning about the impact one has on others is important for symptom resolution and growth, or
- Useful solutions may be better heard from peers.

Family Therapy – The identified patient in family therapy may be a child, adolescent or adult. Family therapy should be considered when:

- The family is affected by either the individual’s condition or the individual’s treatment.
- The individual’s symptoms or lack of functioning is reflective of family problems.
- The family is compromising the individual’s progress.
- The treatment objectives can most efficiently be achieved by working with the family.

- The individual has failed to make expected progress, and family interventions would be expected to improve treatment progress – indicators include medication noncompliance, failure to maintain abstinence from substance abuse or other self-harming behaviors, recurrent hospitalizations.
- The identified individual is a child/adolescent or a young adult still living at home and/or requires parental resources for appropriate functioning.

Medication Management:

- There are a few biologically-based psychiatric conditions that require long-term, continuous medication management and follow-up to prevent or minimize the frequency and severity of acute symptom relapse that could require higher levels of care;
- The need for ongoing medication management does not necessarily indicate that continued outpatient therapy is medically necessary.

Note: Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Behavioral Health Treatment.

Expectations for Outpatient Behavioral Health Treatment:

- The therapist and individual will collaborate to establish clearly defined treatment objectives and to identify ways to measure improvement.
- When the treatment objectives are met, the coverage for treatment will end.
- From time to time, individuals may occasionally have other unresolved problems, but their level of functioning has been restored to baseline. The presence of unresolved issues does not necessarily indicate that continued outpatient therapy is medically necessary.
- The type and degree of functional impairment will be reflected in the treatment plan.
- Treatment will be solution-focused and highly interactive,
- In most cases, there is an expectation that therapy will terminate once the objectives of the treatment episode have been met.
- Extended therapy visits (i.e., sessions lasting more than 50 minutes) and multiple visits per week are not considered

medically necessary unless there is a compelling clinical reason for the request.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **For all modalities of psychotherapy ALL of the following must be met:**
 - A. The individual reports or expresses a subjective level of distress.
 - B. Clinical symptoms result in functional impairment (impairment in ability to complete activities of daily living, occupational functioning, and/or social functioning that is not characteristic of the person when not symptomatic.
 - C. The individual is motivated for, or amenable to, treatment by a mental health professional.

Criteria for Continued Stay

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. The individual continues to experience both psychiatric symptoms and functional impairment.
3. The individual (and family as appropriate) has participated in the development of an individualized treatment plan. The treatment plan should include clearly defined, measurable, and realistic goals and discharge criteria, with an expected time frame for completion.

However, Continued Stay criteria are NOT MET if any of the following are the case:

1. The individual is uncooperative or noncompliant with treatment, and the absence of treatment poses no imminent risk of harm to the welfare of the individual or others.
2. The individual's history provides evidence that additional outpatient therapy will not create further symptom relief and/or change.
3. Treatment is primarily supportive in nature.
4. Treatment is focused on phase of life or quality of life issues (for example, career dissatisfaction, adjusting to new life circumstances in the absence of functional impairments) rather than on treating a psychiatric illness or a substance use disorder.

Halfway House for Behavioral Health Disorders

Note: Halfway House coverage is excluded under many Cigna Behavioral Health benefit plans, and may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Halfway House for Behavioral Health Disorders will:

- Be licensed to provide services for individuals with substance abuse disorders and/or other behavioral health disorders by an appropriate state licensing certification board in the state where the care is provided.
- Provide 24-hour monitoring of the individual and the immediate physical environment to ensure a safe, clean and sober environment, where an individual in treatment for substance abuse problems can continue his/her recovery.
- Have clinical oversight provided by licensed medical professionals or substance abuse counselors.
- Have the capability to provide medical and psychiatric referrals for treatment and follow up of underlying physical and/or psychiatric illnesses, and
- Require abstinence from mood-altering chemicals unless appropriately prescribed by a licensed physician.

- Be used for stabilization of the individual and preparation for transition to a less restrictive level of care with a goal of reintegration into the individual's community.

Admission Considerations for Halfway House for Behavioral Health Disorders:

- A Halfway House admission may be considered when an appropriate, less restrictive level of care is unavailable.
- Relapse should not be the sole criteria for transferring an individual to a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and family, the risk of danger or harm to the individual or others, and the reason for the relapse. An updated and modified treatment plan should then include addressing the barriers to continued relapse, the relapse triggers, and the prevention plan.

Expectations for Halfway House for Behavioral Health Disorders:

- Staff will actively work with the individual to ensure he/she fully participates in substance abuse treatment, which can include onsite or community-based outpatient individual, group, and family treatment, all while residing in the halfway house.
- The staff and program of the Halfway House are focused on reducing the risk of relapse, reinforcing pro-social behaviors, and assisting in community reintegration.
- The Halfway House will have a documented and regularly updated care plan that addresses the individuals' behavioral health needs.
- The discharge plan will include:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **All of the following criteria must be met:**
 - A. The individual is medically stable and not experiencing medical complications that would preclude active participation in treatment. The individual is cognitively able to actively participate in and benefit from behavioral health treatment.

- B. The individual demonstrates an interest in working toward the goal of rehabilitation.
- C. The individual is actively engaged in treatment, which must include onsite and/or community-based outpatient individual, group, and family treatment, Intensive Outpatient Treatment, or Partial Hospitalization, and the staff at the halfway house have reviewed and agree with the treatment plan.
- 3. **One or more of the following criteria must be met:**
 - D. While residing in a non-Halfway House setting, the individual:
 - 1. Has been unsuccessful in achieving sustained abstinence of 6 months or more following active participation in an outpatient rehabilitation program (intensive outpatient and/or partial hospitalization) during the past 12 months, OR
 - 2. Has failed to follow-through with outpatient rehabilitation, including intensive outpatient and/or partial hospitalization, OR
 - 3. Has demonstrated a repeated inability to control his/her impulses to use drugs/alcohol. For an individual with a history of repeated relapses and treatment history involving multiple treatment episodes, there must be evidence of the rehabilitation potential for the proposed admission, with clear interventions, and definition of noncompliance and its management.
 - OR
 - E. The individual's living environment is such that his/her ability to successfully achieve abstinence is jeopardized. Examples would be: the family is opposed to the treatment efforts, the family is actively involved in their own substance abuse, and/or the living situation is severely dysfunctional, OR
 - F. The individual's social, family, and occupational functioning is severely impaired secondary to substance abuse, such that most daily activities revolve around obtaining, using, and recuperating from substance abuse. While the individual is expressing an interest in abstinence, he/she requires 24-hour supportive living environment to engage and maintain therapeutic gains.

Criteria for Continued Stay

All of the following must be met:

- 1. All basic elements of medical necessity continue to be met.
- 2. One or more of the following criteria must be met:
The individual recognizes or identifies with the severity of the behavioral health problem, however, s/he still:
 - A. Requires support to maintain continued sobriety, OR
 - B. Requires support to maintain insight into self-defeating behaviors associated with behavioral health, OR
 - C. Requires support to maintain the problem solving skills necessary to address their behavioral health, OR
 - D. Requires support to manage personal triggers associated with relapse.
- 3. **All of the following must be met:**
 - E. The individual is actively engaged in on site and/or community-based outpatient individual, group, and family treatment, Intensive Outpatient Treatment, or Partial Hospitalization.
 - F. The individual is actively pursuing independent living arrangements.
 - G. There is clinical evidence as to why other living arrangements, with or without the use of other treatment services, would not sustain the individual's progress.
 - H. The individual is improving clinically and progressing towards discharge from the present level of care.
 - I. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.



Section

4

**SUBSTANCE USE
DISORDER TREATMENT**



Acute Inpatient Drug and Alcohol Detoxification

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Acute Inpatient Drug and Alcohol Detoxification is utilized when the following services are needed:

- Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
- Appropriate medical professionals are available, which may include a Psychiatrist, or an Addictionologist and daily nursing staff monitoring.
- Daily monitoring of psychiatric medication effects and side effects, and
- A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Drug and Alcohol Detoxification is utilized when the following services are needed:

- This level of care may be considered after the individual has been evaluated medically in a face-to-face assessment prior to the admission to determine if this level of care is medically necessary and clinically appropriate due to a significant risk of a severe withdrawal syndrome.
- This level of care is not justified by simple intoxication or fear of withdrawal. Therefore, elevated blood alcohol level without any associated withdrawal symptoms is not enough to justify detoxification treatment.
- 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 medical necessity criteria are applied. The individual has to have acute and severe medical problems such as:
 - Acute onset of seizures, severe electrolyte imbalance, gastrointestinal bleeds, cardiac complications, acute liver failure, or other serious medical complications, OR
 - Underlying substance abuse is of such severity that it will likely cause severe and acute medical complications in the near future requiring acute medical management.

Expectations for Acute Inpatient Drug and Alcohol Detoxification:

- A thorough Psychiatric Evaluation is completed within 24-hours of admission.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or Addictionologist.
- Psychiatric follow-up occurs daily or more frequently as needed.

- A medical workup is completed as needed or appropriate.
- Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
- The facility must be able to rapidly assess and address any urgent behavioral and/or physical issues.
- Coordination of treatment planning with community treatment providers, employers or any involved legal authorities is strongly encouraged.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow family integration, a smooth transition and continuation of the recovery process.
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to **provide detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - Family therapy is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

 - **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission that includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. The individual is at risk for a severe withdrawal syndrome evidenced by vital signs changes and/or scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS) and one or more of the following:
 - A. Evidence of Alcohol and/or Sedative-Hypnotic withdrawal. anxiety, agitation, auditory disturbances, clouding of sensorium, delirium, sweating, diarrhea, elevated vital signs (blood pressure, temperature, pulse), headache, nausea and vomiting, seizures, tactile disturbances, tremor and hallucinations.
 - B. Evidence of Opiate withdrawal as manifested by the following: abdominal cramps, agitation and anxiety, lack of appetite, joint pain, sweating, diarrhea, dilated pupils, elevated vital signs (blood pressure, temperature, pulse), irritability, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, and yawning, OR
 - C. Prior complicated and potentially life-threatening withdrawal due to a history of seizures, delirium tremens, or acute psychotic symptoms,

AND
3. **One or more of the following must apply:**
 - D. The presenting signs and symptoms require active treatment that can only be safely and effectively provided in a 24-hour per day setting with nursing care and daily medical interventions.
 - E. The Individual is currently suffering from symptoms of a severe mental illness or has such irrational or bizarre thinking that he/she could not safely participate in a less intensive level of care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**

- A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
- B. If the treatment plan implemented is not leading to measurable clinical improvements and the individual continues to suffer from severe withdrawal symptoms that require active treatment efforts that can only be provided by around-the-clock intensive nursing care and daily monitoring by a physician, OR
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- F. Continued stay is not primarily due to a lack of external supports.

Ambulatory Drug and Alcohol Detoxification

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Ambulatory Drug and Alcohol Detoxification

is utilized when the following services are needed:

- Daily medical monitoring of mild to moderate withdrawal symptoms and adjustment to the medical regimen.
- Appropriate medical professionals are available, which may include a Psychiatrist or an Addictionologist and daily nursing staff monitoring.
- There is 24 -hour access to a physician should unexpected symptoms or worsening of symptoms occur.

Admission Considerations for Ambulatory Drug and Alcohol Detoxification:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician with experience in acute psychiatric emergencies, to determine if this level of care is medically necessary and clinically appropriate.
- The individuals managed at this level of care should not require medical monitoring on a 24-hours-a-day basis.
- The facility should have the ability to step up the individual to an inpatient detoxification level of care, if needed.

Expectations for Ambulatory Drug and Alcohol Detoxification:

- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or Addiction Specialist.
- This level of care is used as a time-limited level of intervention to stabilize acute withdrawal symptoms, facilitating a transition to lower levels of care when clinically indicated.
- Individuals and/or their supports are capable of accessing emergency services.
- Individuals in this level of care are able to live in the community without the restrictions of a 24-hour supervised setting
- There should be an emphasis on attending community based self-help groups, and development of social support network to ensure long-term sobriety.
- Coordination of treatment planning with community treatment providers, employers or any involved legal authorities is strongly encouraged.
- Psychiatric treatment is addressed concurrently to improve the individual's potential for recovery.



- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws.

- The family should be able to provide detailed initial history to clarify and understand the current and past events leading up to the admission, so that all of the available information can be considered in the development of a comprehensive treatment plan.
- **A Discharge Plan** that starts at the time of admission that includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. Evidence of Alcohol and/or Sedative-Hypnotic withdrawal as manifested by the following: anxiety, sweating, diarrhea, elevated vital signs (blood pressure, temperature, pulse), headache, nausea and vomiting, and tremor. OR
 - B. Evidence of Opiate withdrawal as manifested by the following: abdominal cramps, agitation and anxiety, lack of appetite, joint pain, sweating, diarrhea, dilated pupils, elevated vital signs (blood pressure, temperature, pulse), irritability, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, and yawning.AND
3. The presenting signs/symptoms must cause clinically significant distress or impairment of social, occupational, or other important area of functioning, AND
4. The individual does not require around-the-clock nursing care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity,
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be

safely and effectively treated at a less restrictive level of care,
OR

- B. If the treatment plan implemented is not leading to measurable clinical improvements and the individual continues to suffer from severe withdrawal symptoms that require active treatment efforts that can only be provided by around-the-clock intensive nursing care and daily monitoring by a physician, OR
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- F. Continued stay is not primarily due to a lack of external supports.

Acute Inpatient Substance Use Disorders Treatment

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Acute Inpatient Substance Use Disorders Treatment is utilized when the following services are needed:

- Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
- Timely assessment and medically-necessary treatment of co-existing acute medical or psychiatric problems.
- Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others.
- Daily monitoring of medication effects and side effects.
- A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Note: *Acute Inpatient Substance Use Disorders Treatment may also be identified as Inpatient Rehabilitation, Mentally Ill Chemical Abuse (MICA) Treatment, or Dual Diagnosis Inpatient Treatment.*

Admission Considerations for Inpatient Treatment for Substance Use Disorders:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician, with experience in acute psychiatric and medical emergencies, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Alternative medical, substance use detoxification, psychiatric treatment programs, are considered and referrals made when clinically indicated.
- Substance abuse inpatient treatment may be a consideration when appropriate alternative less restrictive levels of care are unavailable.

Expectations for Inpatient Treatment for Substance Use Disorders:

- A thorough Evaluation by a Psychiatrist or Addictionologist is completed within 24-hours of admission.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified Psychiatrist or Addictionologist.
- A medical work up is completed as needed or appropriate.
- Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
- The facility must be able to rapidly assess and address any urgent behavioral and/or physical issues
- There is adequate nursing support, along with staffing by appropriately-trained clinicians, and availability of appropriate physician expertise (such as Psychiatrist or Addictionologist).

- The facility has the capability of obtaining necessary consultation(s) based on individual's clinical needs such as pain management specialist for individuals with significant pain issues.
- The facility has the capability of monitoring individual's daily, medical functioning. Such clinical monitoring may include measurement of the vital signs, performing objective clinical assessment(s) to monitor for prolonged withdrawal and obtaining necessary laboratory work up, as indicated.
- Treatment is focused on initial engagement in substance abuse rehabilitation and development of a plan for successful transition to less restrictive settings and community reintegration.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation).
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
 - **The Treatment Plan is not based on a pre-established programmed plan or time frames.**
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - Family therapy is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)
 - **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **All of the following must be met:**
 - A. Withdrawal symptoms, if present, are not life threatening and can be safely monitored.
 - B. The individual is not experiencing medical complications that would preclude active participation in treatment, AND
 - C. The individual is cognitively able to actively participate and benefit from the treatment provided,
3. **One or more of the following criteria must be met:**
 - D. The individual demonstrates a clear and reasonable danger of imminent harm to self or others that is caused by or exacerbated by the current active substance use disorder as evidenced by one of the following:
 1. Current plan or intent to harm self with an available and lethal means, OR
 2. Highly lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.

OR

 - E. Inability to care adequately for one's physical safety due to disordered, disorganized or bizarre behavior, OR
 - F. Current plan/intent to harm others with available and lethal means with inability to plan reliably for safety, OR
 - G. Violent, unpredictable, or poorly controlled behavior that represents an imminent serious harm to others, OR
 - H. The individual's medical condition and continued substance use places the individual in imminent danger of serious damage to his/her physical health or to a current pregnancy. The individual requires 24-hour monitoring, but not the full resources of an acute care hospital, OR

- I. Less restrictive levels of care are unavailable for safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity,
2. **At least one of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Residential Substance Use Disorder Treatment

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;

- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Residential Substance Use Disorder Treatment:

- A licensed substance abuse facility with 7 day a week, 24-hour around-the-clock supervision on a unit that is not locked.
- Residential Treatment Programs are made up by a multidisciplinary team led by a board certified/eligible psychiatrist.
- A nurse or psychiatrist is on site 24/7 to assist with medical issues/crisis intervention and medication administration as needed.
- Treatment is focused on improving functioning rather than primarily for the purpose of maintenance of the long-term gains made in an earlier program.
- There are a variety of residential settings that are not medically necessary treatment programs. For example:
 - Group Homes
 - Other Supportive Housing
 - Therapeutic schools and
 - Most Wilderness Programs
- Residential treatment coverage is not based on a preset number of days. A standardized program such as a "28-Day Rehab Program" is not considered as a medically necessary reason for admission or continued stay at this level of care.
- Residential treatment is a transitional, structured environment to allow the individual to successfully reintegrate into a community-based living arrangement. It can not be considered a long-term substitute for lack of available sober, supportive living environment(s) in the community.

Admission Considerations for Residential Substance Use Disorder Treatment:

Prior to admission, there has been a face-to-face assessment prior to admission, to determine if this level of care is medically necessary and clinically appropriate.

- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Substance Abuse Residential treatment may be authorized when appropriate alternative less restrictive levels of care are unavailable.
- Relapse should not be the sole criterion for managing an individual in a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and the family; the risk of danger or harm to the individual or others; and the reason for the relapse.

Expectations for Residential Substance Use Disorder Treatment:

- Residential treatment should occur as close as possible to the home to which the individual will be discharged. If out-of-area placement is unavoidable, and family is available, there must be a facility commitment to assure ongoing family involvement with the individual and facility.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The treatment plan includes realistic and achievable treatment goals, and a discharge plan with specific timelines for expected implementation and completion.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not

be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **A Discharge Plan** that starts at the time of admission that includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments.
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
- Continuation in this level of care because alternative placement is not available is not justification for continued authorization to the residential treatment facility.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **All of the following must be met:**
 - A. Withdrawal symptoms, if present, are not life threatening and can be safely monitored at this level of care.
 - B. The individual is not experiencing medical complications that would preclude active participation in treatment.
 - C. The individual is cognitively able to actively participate and benefit from the treatment provided.
 - D. There is clear and consistent evidence that the individual demonstrates a genuine interest and internal motivation in working towards the goal of long-term, successful recovery rehabilitation.
3. **At least one of the following criteria must be met:**
 - E. The individual suffers from a severe, uncontrolled, co-occurring psychiatric illness or severe behavioral

disturbance that interferes with he/she ability to successfully participate in a less restrictive level of care, OR

- F. The individual's living environment is such that his/her ability to successfully achieve abstinence is jeopardized. Examples would be: the family is opposed to the treatment efforts, the family is actively involved in their own substance abuse, or the living situation is severely dysfunctional, OR
- G. The individual's social, family, and occupational functioning is severely impaired secondary to substance abuse such that most of their daily activities revolve around obtaining, using and recuperating from substance abuse. While the individual is expressing an interest in abstinence, he/she requires 24-hour supervision to engage and maintain therapeutic gains from the program, OR
- H. The individual:
 - 1. Has been unsuccessful in achieving sustained abstinence of 6 months or more following active participation in two outpatient rehabilitation programs (intensive outpatient and/or partial hospitalization) in the past 12 months; OR
 - 2. Has failed to follow through with outpatient rehabilitation, including partial hospitalization, after two or more inpatient detoxifications in the past 12 months; OR
 - 3. The individual demonstrates repeated inability to control his/her impulses to use illicit substances and is in imminent danger of relapse with resultant risk of harm to self (medically/behaviorally), or others. This is of such severity that it requires 24-hour monitoring/support/intervention. For individuals with a history of repeated relapses involving multiple treatment episodes, there must be evidence of the rehabilitative potential for the proposed admission, with clear interventions to address non-adherence/poor response to past treatment episodes and reduction of future of relapse risk.

Criteria for Continued Stay

All of the following must be met:

- 1. The individual continues to meet all basic elements of medical necessity.
- 2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be

safely and effectively treated at a less restrictive level of care, OR

- B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
- 3. All of the following must be met:**
- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Partial Hospitalization Substance Use Disorder Treatment

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Partial Hospitalization for Substance Use Disorder

provides a coordinated, intense, comprehensive, multidisciplinary treatment for individuals who can be maintained safely in the community at a minimal level of functioning if closely monitored. This level of care should be considered for individuals:

- Who are having significant difficulties maintaining sobriety, which is affecting their daily functioning at work, parenting, and/or with other activities of daily living. Treatment provided in this setting is essentially the same in nature and intensity as is provided in a substance abuse residential setting but without the need of 24-hour supervision. As such the role of this level of care is to provide substance abuse treatment, structure, and supervision while the individual develops the coping that will be needed to maintain sobriety while continuing treatment at less restrictive levels of care.
- Who may present high risk of relapse, but is able to develop a plan to maintain sobriety in the community without 24-hour supervision.

Note: *This level of care should not be confused with the sub-acute “Day Programs” where the focus is on more long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.*

Admission Considerations for Partial Hospitalization for Substance Use Disorders:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician with experience in substance abuse treatment, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate but this level of care could also be the initial level of care authorized.
- Substance Abuse Partial hospitalization may be authorized when appropriate alternative less restrictive levels of care are unavailable. This level of care can also be the initial level of care authorized.
- Relapse should not be the sole criteria for transferring an individual to a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and family, the risk of danger or harm to the individual or others, and the reason for the relapse.

Expectations for Partial Hospitalization for Substance Use Disorders:

- Individuals in this level of care:
 - Are typically in a structured treatment program 5-6 hours per day, 5 days per week.
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
 - Live in the community without the restrictions of a 24-hour supervised setting
 - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
- The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or Addiction Specialist.
- This level of care is used as a time-limited level of intervention to stabilize acute symptoms, facilitating a transition to lower levels of care when clinically indicated.
- Individuals and/or their supports are capable of accessing emergency services.
- There should be an emphasis on attending community based self-help groups, and development of social support network to ensure long-term sobriety.
- Coordination of treatment planning with community treatment providers, employers or any involved legal authorities is strongly encouraged.
- Psychiatric treatment is addressed concurrently to improve the individual's potential for recovery.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation).
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition

back to outpatient services, family integration, and continuation of the recovery process.

- **The Treatment Plan is not based on a pre-established programmed plan or time frames.**
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments.
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of Medical Necessity must be met.
2. **All of the following must be met:**
 - A. The individual is not demonstrating any life-threatening withdrawal symptoms that require acute inpatient detoxification.
 - B. The individual is not suffering from medical or psychiatric complications that would inhibit their ability to actively participate in and benefit from the treatment provided, or that would require 24-hour supervision.

- C. The individual has suffered significant impairment in social, family, and/or work functioning secondary to substance abuse to the extent that he/she is not able to participate in routine daily activities and has not been able to employ the necessary coping skills to compensate for this. There is imminent likelihood of relapse with dangerous consequences as evidenced by similar past behaviors without this level of care.
- D. The individual is unable to maintain abstinence without daily structured treatment intervention of greater intensity/frequency than substance abuse intensive outpatient treatment, or the individual has documented evidence of repeated relapses, and inability to carry out treatment plan objectives in an intensive outpatient program.
- E. The individual demonstrates a genuine interest and internal motivation in working towards the goal of rehabilitation. The individual understands and can comply with the requirements of a partial hospital program and the individual is likely to participate in treatment with the structure and supervision afforded by the program.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**

- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- F. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Substance Use Disorder Treatment

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Intensive Outpatient Treatment for Substance Use Disorders

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for an individual who can maintain some ability to fulfill family, student, or work activities.

- The severity of psychosocial stressors and often-complex family dysfunction are such that the multi-disciplinary treatment plan developed at this level of care is necessary to stabilize the individual.
- Despite these stressors, the individual is not at imminent risk for serious bodily injury due to aggression toward self or others.

- IOP is appropriate to consider for complex or refractory clinical situations that would otherwise result in the need for a more restrictive level of care. The duration of treatment and frequency of attendance are continually evaluated and adjusted according to the individual severity of signs and symptoms. Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- This level of care can be the first level of care authorized, to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant returned to a less structured outpatient setting.

Note: Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Behavioral Health Treatment.

Admission Considerations for Intensive Outpatient Treatment for Substance Use Disorders:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician, with experience in chemical dependency, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Intensive Outpatient Program may be authorized when alternative levels of care that may be appropriate are unavailable.

Expectations for Intensive Outpatient Treatment for Substance Use Disorders:

- Individuals who are at this level of care:
 - Are typically in a structured treatment program 2-3 hours per day, 3-5 days per week.
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
 - Live in the community without the restrictions of a 24-hour supervised setting.
 - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

- The facility provides a structured program, which is staffed by trained professionals in the treatment of chemical dependency and abuse.
- A psychiatrist or addictionologist is available for consultation, as needed.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation).
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)
 - **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments.
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **All of the following must be met:**
 - A. The individual is not demonstrating any life-threatening withdrawal symptoms that require acute inpatient detoxification, and is not at serious risk of harm to self or others.
 - B. The individual is not suffering from medical/psychiatric complications of his/her substance abuse that would inhibit the individual's ability to actively participate in and benefit from participation in the treatment.
 - C. The individual is unable to maintain abstinence without a structured treatment intervention during a portion of the day.
 - D. The individual has a support system to help the individual adhere to the treatment plan and service schedules. If the individual has no primary support system, he/she has the skills to develop supports and/or become involved in a self-help system.
 - E. The individual suffers significant impairment in social, medical, family and/or work functioning secondary to substance abuse.
 - F. The individual demonstrates a genuine interest and internal motivation in working towards the goal of rehabilitation.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Medication Assisted Treatment (MAT) for Opiate Dependence

Note: Coverage for Medication Assisted Treatment that includes Methadone Maintenance is explicitly excluded under many Cigna Behavioral Health benefit plans, and may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Medication Assisted Treatment (MAT) for Opioid Dependence

is an approved standard of practice for maintenance, detoxification and medically supervised withdrawal.



- There are currently two medications that are available and approved for use in opioid maintenance treatment: methadone and sublingual formulations of buprenorphine.
- Opioid maintenance treatment can offer pharmacologic benefits that help to support an individual's efforts to achieve and sustain abstinence. It also can help with retention in treatment, so that medical and psychosocial issues may be addressed.

Note: These criteria do NOT apply to outpatient treatment of opiate dependence that does not involve the use of opiate-replacement

medications. This includes, but is not limited to, treatment with Vivitrol (naltrexone). Such treatment is covered under the criteria for Outpatient Behavioral Health Treatment.

Admission Considerations for Medication Assisted Treatment (MAT) for Opioid Dependence:

- This level of care should be considered only after a complete substance abuse assessment, and consideration of all available alternative levels of care.

- At times, MAT may also be utilized as part of a comprehensive program that includes substance abuse treatment at other levels of care as well.

Expectations for Medication Assisted Treatment (MAT) for Opioid Dependence:

- Medication Assisted Treatment (MAT) for Opioid Dependence is limited to providers or programs that have the appropriate DEA certifications and meet all legally mandated requirements.

Criteria for Initiation of Treatment

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. The individual has a diagnosis of opiate dependence.
3. **At least one of the following criteria must be met:**
 - A. The individual has a one-year history of dependence on opiates, OR
 - B. The individual is currently pregnant.
4. **All of the following must be met:**
 - C. The individual is willing to adhere to treatment plans and recommendations.
 - D. The individual is actively engaged in treatment, which may include on-site or community-based outpatient individual, group, or family treatment, or IOP or PHP.
 - E. The individual has an understanding of the need for compliance with medication dosages.
 - F. The individual has a supportive and consistent recovery environment.
 - G. If under 18, the individual's parental consent is obtained.
 - H. The individual does not meet any of the following exclusion criteria as defined below:

Exclusion Criteria:

1. The individual has the presence of active suicidal thoughts.
2. The individual has active alcohol abuse or dependence without engagement in an active treatment plan.
3. The individual has mental illness that would interfere with compliance or adherence to treatment protocols.
4. The individual has a history of prior adverse reactions to MAT.
5. The individual has a severe medical illness that makes dosing unsafe.

Note: For medication-assisted treatment, methadone maintenance is considered the treatment of choice in pregnant women, although buprenorphine may also be useful in selected cases

Criteria for Continued Stay

All of the following must be met:

1. The individual's MAT medication dose is safe and adequate.
2. The individual is compliant with attendance and dosing plans.
3. The individual remains willing to follow through with treatment plans and recommendations.
4. The individual has a supportive and consistent recovery environment.
5. Routine, periodic drug screening results are negative, or if positive, have led to treatment plan changes.

Voluntary Tapering and Discontinuation:

All of the following must be met:

1. The individual has a consistent and supportive recovery environment.
2. The individual is actively involved in a relapse prevention program.
3. The individual has the necessary support systems in place to make a long-term treatment commitment: i.e., transportation, support groups as well as familial or social contacts.

Section

5

EATING DISORDER TREATMENT



Acute Inpatient Eating Disorder Treatment

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Inpatient Treatment for Eating Disorders

is utilized when the following services are needed:

- Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
- Acute treatments to control behavior and symptoms requiring stabilization.
- Acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others.
- Daily monitoring of psychiatric medication effects and side effects.

- A contained environment for specific treatments that could not be safely done in a less-restrictive setting.

Admission Considerations for Inpatient Treatment for Eating Disorders:

- Prior to admission, there has been a face-to-face medical and psychiatric evaluation of the individual to determine if this level of care is medically necessary and clinically appropriate.
- The medical evaluation should particularly focus on weight, cardiac status, metabolic status, vital signs, and relevant lab values.
- The level of care determination should not be based on a single or limited number of physical parameters such as weight alone.
- Most individuals with uncomplicated Bulimia Nervosa do not require hospitalization unless there are:
 - Severe disabling symptoms that have not responded to outpatient treatment, and/or
 - Serious concurrent general medical problems (e.g., metabolic abnormalities, hematemesis, vital sign changes, or the appearance of uncontrolled vomiting).

Expectations for Inpatient Treatment for Eating Disorders:

- A thorough Psychiatric evaluation is completed within 24-hours of admission.
- A medical work up should be completed as needed or appropriate.
- Within 48 hours of admission, outreach will be done with existing providers and family members to obtain any relevant history and clinical information.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.

- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation).
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of Medical Necessity must be met.
2. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder NOS (Not Otherwise Specified).
3. **One or more of the following criteria must be met:**
 - A. The individual has medical instability with abnormalities in some or all vital signs: heart rate (less than 50), temperature

(less than 97 F), blood pressure (less than 90/60 mm Hg for adults OR less than 80/50 for children and adolescents), orthostatic pulse increase (more than 20 beats per minute), orthostatic blood pressure decrease (more than 10-20 mm), OR

- B. The individual has abnormal relevant lab values such as low serum glucose (less than 60 mg/dl), electrolyte imbalances, low potassium (less than 3.2 mEq/L), low Phosphorus, or low Magnesium, OR
- C. The individual has significant medical symptoms such as evidence of dehydration, significantly impaired liver, kidney, heart function; or poorly controlled diabetes, OR
- D. Individuals with a significant decrease in Ideal Body Weight, as indicated by one of the following:
 1. A Body Mass Index (BMI) less than 16, OR
 2. For children and adolescents, a rapid, recent, continuing weight decline due to food refusal. Growth charts should be utilized for children and adolescents, OR
 3. If BMI is greater than 16, there is evidence of any one of the following: weight loss or fluctuation of two or more pounds/week, OR weight loss associated with medical instability unexplained by any other medical condition.

OR

- E. The individual's condition requires around-the-clock medical/nursing intervention for issues of imminent harm to self or others or to provide immediate interruption of the food restriction, excessive exercise, bingeing, purging and/or use of laxatives/diet pills/diuretics, to avoid impending and life threatening harm due to medical consequences or to avoid impending and life threatening complications to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation), OR
- F. The individual's eating disorder symptoms are not responding to an adequate therapeutic trial in a less-intensive setting (e.g., residential or partial hospital) or there is clinical evidence that the individual is not likely to respond in a less-intensive setting.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**

- A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
- B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- F. Continued stay is not primarily due to a lack of external supports.

Residential Eating Disorders Treatment

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description - Residential Eating Disorders Treatment:

- A licensed eating disorder facility with 7 day a week, 24-hour around-the-clock supervision on a unit that is not locked.
- Residential Treatment Programs are made up by a multidisciplinary team led by a board certified/eligible psychiatrist.
- A nurse or psychiatrist is on site 24/7 to assist with medical issues/crisis intervention and medication administration as needed.
- Treatment is focused on improving functioning rather than primarily for the purpose of maintenance of the long-term gains made in an earlier program.
- There are a variety of residential settings that are not medically necessary treatment programs. For example:
 - Group Homes
 - Other Supportive Housing
 - Therapeutic School
 - Most wilderness programs
- Residential treatment coverage is not based on a preset number of days. A standardized program such as a “30-Day Treatment Program” is not considered as a medically necessary reason for admission or continued stay at this level of care.
- Residential treatment is a transitional, structured environment that will allow the individual to successfully reintegrate into a community-based living arrangement. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community.

Admission Considerations for Residential Eating Disorders Treatment:

- Prior to admission there has been a face-to-face assessment with the individual and family prior to admission, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate
- Eating Disorder Residential treatment may be authorized when appropriate alternative less restrictive levels of care are unavailable

Expectations for Residential Eating Disorders Treatment:

Residential treatment should occur as close as possible to the home to which the individual will be discharged. If out-of-area

placement is unavoidable, and family is available, there must be a facility commitment to assure ongoing family involvement with the individual and facility.

- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation.
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The treatment plan includes realistic and achievable treatment goals, and a discharge plan with specific timelines for expected implementation and completion.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

- **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to **provide detailed initial** history to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a face-to-face setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **A Discharge Plan** that starts at the time of admission that includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

- Continuation in this level of care because alternative placement is not available is not justification for continued authorization to the residential treatment facility.

Criteria for Admission

All of the following must be met:

1. All basic elements of Medical Necessity must be met.
2. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified.
3. **One or more of the following criteria must be met:**
 - A. The individual has failed an adequate trial of treatment in a less intensive setting such as partial hospital or intensive outpatient or needs this level of care to prevent hospitalization or there is clinical evidence that the individual is not likely to respond in a less-intensive setting, OR
 - B. Structure and supervision is needed at all meals to prevent restricting or bingeing-purging. The family/support system is unable to provide this level of monitoring, OR
 - C. For individuals diagnosed with Anorexia Nervosa, the body mass Index (BMI) is greater than 16. Growth charts should be utilized for children and adolescents. If BMI is greater than 17, then one of the following is present:
 1. Weight loss of two or more pounds/week, or
 2. For children and adolescents, a rapid, recent, continuing weight decline due to food refusal. Growth charts should be utilized for children and adolescents.OR
 - D. The individual's condition requires around-the-clock intervention to provide interruption of the food restriction, excessive exercise, bingeing, purging and/or use of laxatives/diet pills/diuretics to avoid harm due to life threatening medical consequences or to avoid life threatening complications due to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes) or psychiatric condition.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be

safely and effectively treated at a less restrictive level of care, OR

- B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
- 3. All of the following must be met:**
- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Partial Hospitalization Eating Disorders Treatment

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;



- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description - Partial Hospitalization Eating Disorders Treatment

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for individuals who can be maintained safely in the community at a minimal level of functioning if closely monitored. This level of care should be considered for individuals:

- Who are having significant acute difficulties with eating disorder symptoms to the extent that is affecting daily functioning at work, parenting, school, and/or with other

activities of daily living. Treatment provided in this setting is essentially the same in nature and intensity as is provided in an inpatient hospital setting. As such the role of this level of care is to respond to acute situations, which absent of this level of care would potentially result into life-threatening emergencies.

- Who may present ongoing risk of harm to him/herself or others, but is able to develop a plan to maintain safety in the community without 24-hour supervision.

Note: This level of care should not be confused with the sub-acute “Day Programs” where the focus is on more long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.

Admission Considerations for Partial Hospitalization Eating Disorders Treatment:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician with experience in acute psychiatric emergencies, to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- Psychiatric Partial hospitalization may be authorized when appropriate alternative less restrictive levels of care are unavailable. This level of care can also be the initial level of care authorized.

Expectations for Partial Hospitalization Eating Disorders Treatment:

- Individuals who are at this level of care:
 - Are typically in a structured treatment program 5-6 hours per day, 5 days per week.
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
 - Live in the community without the restrictions of a 24-hour supervised setting
 - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
- The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist
- This level of care is used as a time-limited level of intervention to stabilize acute symptoms, facilitating a transition to lower levels of care when clinically indicated.
- Individuals and/or their supports are capable of accessing emergency services.
- **An Individualized Treatment Plan** is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation).

- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **The Treatment Plan is not based on a pre-established programmed plan or time frames.**

- **Family Involvement** - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face** setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

– **Planning for Discharge**

- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met:

1. All basic elements of Medical Necessity must be met.
2. **All of the following must be met:**
 - A. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified.
 - B. There is evidence of all of the following:

1. The individual has the capacity for reliable attendance and active participation in the treatment plan.
 2. The risk of harm to self, others, or property has been assessed by a mental health professional as being due to a psychiatric illness and not requiring a more intensive level of care.
 3. The individual is capable of developing a safety plan for when not at the partial hospital and seeking emergency assistance if safety risks are heightened, AND
 4. The individual has support systems available to assist them when not at the partial hospital if necessary.
 5. Less restrictive or intensive levels of treatment are not appropriate to meet the individual's needs or have been tried and were unsuccessful.
- C. The individual is medically stable to the extent that more extensive medical monitoring is not required. The individual can reduce incidents of purging in an unstructured setting. The individual requires a moderate degree of structure for eating full meals and gaining weight but not so much that 24-hour per day monitoring is required. For individuals diagnosed with Anorexia Nervosa, the body mass Index (BMI) is greater than 16. Growth charts should be utilized for children and adolescents,
- 3. One or more of the following criteria must be met:**
- D. The individual has failed an adequate trial of treatment in a less intensive setting such as an intensive outpatient program or needs this level of care to prevent hospitalization or there is clinical evidence that the individual is not likely to respond in a less-intensive setting, OR
 - E. The individual requires a structured program to avoid complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes). For children and adolescents, a rapid, recent, continuing weight decline due to food refusal. Growth charts should be utilized for children and adolescents, OR
 - F. The individual has recently demonstrated actions of or made serious threats of self harm or harm to others but does not require a 24-hour monitoring environment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**

- A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
- 3. All of the following must be met:**
- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Eating Disorders Treatment

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description - Intensive Outpatient Eating Disorders Treatment

provides a coordinated, intense, comprehensive, multi-disciplinary treatment for an individual who can maintain some ability to fulfill family, student, or work activities.

- The severity of psychosocial stressors and often-complex family dysfunction are such that the multi-disciplinary treatment plan developed at this level of care is necessary to stabilize the individual.
- Despite these stressors, the individual is not at imminent risk for serious bodily injury due to aggression toward self or others.
- Intensive Outpatient Treatment for Eating Disorders is appropriate to consider for complex or refractory clinical situations that would otherwise result in the need for a more restrictive level of care. The duration of treatment and frequency of attendance are continually evaluated and adjusted according to the individual severity of signs and symptoms. Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- This level of care can be the first level of care authorized, to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant returned to a less structured outpatient setting.

Note:

- This level of care should not be confused with the sub-acute “Day Programs” where the focus is on more long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.
- **Low Intensity Outpatient Programs and Aftercare Services** are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Behavioral Health Treatment.

Admission Considerations for Intensive Outpatient Eating Disorders Treatment:

- Prior to admission, there has been a face-to-face individual assessment by a licensed clinician to determine if this level of care is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

- Intensive Outpatient Program may be authorized when alternative levels of care that may be appropriate are unavailable.
- The level of care determination should not be based on a single or limited number of physical parameters such as weight alone.

Expectations for Intensive Outpatient Eating Disorders Treatment:

- Individuals who are at this level of care:
 - Will have the opportunity to be exposed to circumstances that may have contributed to the admission and practice their coping skills.
 - Live in the community without the restrictions of a 24-hour supervised setting
 - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
- The individual should be medically monitored.
- An Individualized Treatment Plan is completed within 24-hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality, social supports, education, living situation).
 - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
- **Family Involvement** - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Planning for Discharge**
- **A Discharge Plan** that starts at the time of admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments
 - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Criteria for Admission

All of the following must be met

1. All basic elements of Medical Necessity must be met.
2. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified.
3. One or more of the following criteria must be met:
 - A. For individuals diagnosed with Anorexia Nervosa, the body mass Index (BMI) is greater than 17. Growth charts should be utilized for children and adolescents. The individual can greatly reduce incidents of purging in an unstructured setting. The individual requires some degree of structure for eating full meals and gaining weight but not as much as typically provided in a partial hospitalization program, OR
 - B. The individual suffers significant impairment in medical, school and/or work functioning secondary to the eating disorder that requires a more intensive and structured program than outpatient, OR
 - C. If the individual, while intermittently experiencing thoughts of harm to self or others, is able to develop a safety plan with the provider to access emergency services and is considered at low-risk so that a more intensive level of care is not required, OR
 - D. Lack of improvement or non-compliance with outpatient treatment requires the interventions of a multi-disciplinary team to stabilize the individual and prevent a more intensive level of care being required, OR
 - E. The individual's past history indicates that when similar clinical circumstances occurred, less restrictive treatment

was not sufficient to prevent clinical deterioration or avert the need for a more intensive level of care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - F. Continued stay is not primarily due to a lack of external supports.



Section

6

BEHAVIORAL HEALTH
ASSESSMENT AND
TREATMENT PROCEDURES



Crisis Stabilization

In considering the appropriateness of any level of care, all basic elements of the medical necessity definition should be met:

Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – 23-Hour Crisis Stabilization provides evaluation and intervention for individuals with acute symptoms of a behavioral health disorder when the clinical presentation does not immediately indicate the need for a higher level of care. It is considered when an individual presents with:

- Acute symptoms of mental illness
- Impairments caused by abuse of substances.
- Behavior problems of a serious magnitude which cause immediate interference with the individual’s ability to function at work, in school, within the family, or in social interactions.

Settings where service can be provided include:

- A hospital – only when the facility is able to provide this service for no more than 23 hours.

- A licensed Crisis Intervention Center (either free-standing or attached to a hospital) that is able to provide the service for no more than 23 hours.
- An outpatient clinical setting.

The ultimate setting is determined by the individual’s clinical presentation, available resources, and by the facility’s ability to begin active interventions within six hours of presentation.

Focus of the intervention:

- Psychosocial factors relevant to the crisis.
- Assessment for risk of harm to self or others.
- Assessment of support networks.
- A complete medical evaluation and basic medical procedures as indicated.
- Identification and mobilization of other available services.
- Evaluation of the individual’s willingness and reliability to participate in a mutually-acceptable treatment plan.

Note: *This level of care is not appropriate when, based on clinical presentation or history, there is a strong likelihood that the individual will need the intensive structure of Acute Inpatient Treatment for more than 23 hours.*

Description – Crisis Stabilization Bed/Unit (greater than 23 hours):

The use of Crisis Stabilization Bed/Unit (greater than 23 hours) is likely to be infrequent, but may apply in those cases where a Crisis Stabilization Unit exists outside of an accredited hospital, but where 24-hour supervised and medically monitored services are available.

This service provides:

- The same type and intensity as a Crisis Stabilization Program offering intervention for 23 hours or less, but where 24-hour supervised and medically monitored services are available for those individuals needing:
 - Longer periods of observation.

- More time for assessments.
- Safe environment for more than 23 hours.
- Psychiatric consultation -- to occur ideally as soon as possible following admission, but definitely prior to discharge.
- A complete medical evaluation and basic medical procedures as indicated.
- Evaluation of family and social support systems that identify both opportunities and challenges, and a plan to address the latter.

When medical services are not available on site, the program must be able to ensure that the individual will be linked to appropriate treatment and providers within a reasonable timeframe.

Focus of the Intervention

The goals of the intervention at this level of care are similar to the goals of a 23 hour-or less Crisis Stabilization program and include similar criteria:

- Reduction of potential for harm to self or others
- Ability to begin active interventions within 6 hours of admission by a mental health professional
- Identification and mobilization of available resources including support networks
- The crisis stabilization intervention should focus on factors relevant to the crisis.
- Appropriate Interventions include assessment of support networks, identification and assessment of available services, mobilization of those services, and an estimate of the individual's ability to access services and participate in the treatment plan.

Note: *This level of care is not appropriate for an individual who, by clinical presentation or history, requires the intensive structure of Acute Inpatient Treatment for safety and stabilization.*

The facility setting for a crisis stabilization bed, whether less than or greater than 23-hours, is within a unit that provides around-the-clock nursing and/or mental health staff supervision and continuous observation and control of behaviors to insure the safety of the individual and/or others..

Description – Outpatient Crisis Stabilization:

Outpatient Crisis Stabilization occurs as an ambulatory program. The services provided are rapid and time-limited and aim to avoid further decrease in level of functioning. The services are intensified as needed and are available 24-hours a day, seven days per week.

This service provides:

- Assessments to determine risk of harm to self or others and/or determine need for secure environment.
- Evaluation for medical emergency and ability to safely transport to medical facility if necessary.
- Intervention in any one of a number of settings including outpatient therapy office, facility-based outpatient department, or in the home of an individual with safety of all parties a primary concern.

Focus of the Intervention

- Psychosocial factors relevant to the crisis.
- Assessment for risk of harm to self or others.
- Assessment of support networks.
- Identification and mobilization of other available services.
- Evaluation of the individual's willingness and reliability to access and participate in a mutually-acceptable treatment plan.
- Development of a short-term, evidence-based treatment plan than includes a family or support system evaluation or therapy session.
- Plan for follow-up that includes collaboration with Cigna, the individual's psychiatrist, other mental health providers, the individual's primary care physician, and/or other community resources as appropriate.

Note: *This level of care does not include crisis stabilization services provided within an emergency room setting. Emergency Room services are generally covered by an individual's health plan benefits.*

Criteria for Admission

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The individual is expressing suicidal ideation, and/or hopelessness and helplessness likely to lead to self-injury, which must continue to be evaluated for severity and lethality. Because of lack of more immediately available support systems, this cannot be evaluated in a less restrictive setting, OR
 - B. The individual is threatening harm to others or has acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation. This evaluation includes attempting to discern the etiology of such behaviors, especially if suspected to be chemically or organically induced, OR

- C. The individual is presenting with significant emotional and/or thought process disturbances which interfere with his/her judgment so as to seriously endanger the individual if not evaluated and stabilized on an emergency basis, OR
- D. The individual is showing severe signs of an acute stress reaction to a recent destabilizing event that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment. In addition, there is a need for a time-limited intervention to allow time for mobilization of additional resources and supports, OR
- E. The individual is in current treatment but the nature of the individual's course of illness is one characterized with recurrent presentations of self-injury or impaired thinking that responds rapidly to structured interventions. This level of care should only be considered when support systems and/or the previously designed crisis plan of the individual and his/her therapist have not been sufficient and the likelihood for further deterioration is high, OR
- F. The individual is presenting with intoxication that causes significant emotional, behavioral, medical, or thought process disturbance that interfere with his/her judgment so as to seriously endanger the individual if not monitored and evaluated for the need of ambulatory or inpatient detoxification.

Criteria for Continued Stay in Crisis Stabilization Bed/Unit (greater than 23 hours):

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**



- D. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- E. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- F. Continued stay is not primarily due to a lack of external supports.

Electroconvulsive Therapy (ECT)

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment,

would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description – Electroconvulsive Therapy (ECT)

- ECT is most often used to treat severe depression that fails to respond to medications or for individuals who are unable to tolerate the side effects associated with the medications.
- This procedure may be the treatment of choice when there is a need for rapid stabilization for individuals who are at acute risk of harm due to severe agitation, delusions, suicidality, not eating or drinking
- ECT also may be the treatment of choice for individuals with catatonia (a potentially life threatening trance-like state).
- ECT is also used to stabilize bipolar illness during extreme episodes of mania or depression and to halt psychotic episodes associated with schizophrenia.

Note: *This treatment may be administered on either an outpatient or inpatient basis.*

Treatment Considerations for Electroconvulsive Therapy (ECT):

- The severity of the psychiatric illness requires a rapid, definitive response.
- The risk of ECT is less than the risks of other treatments.
- There is a history of good response to ECT or poor response to medication in previous episodes of illness; or
- The individual or legal representative, having discussed all alternative treatments, and being aware of and able to comprehend the risks and potential benefits of ECT, chooses ECT as his or her preferred treatment.
- If the individual receiving ECT has a severe psychiatric illness that requires Acute Psychiatric Hospitalization, the individual may then continue this treatment on an outpatient basis

once stabilized to a point that 24-hour inpatient care is no longer a medical necessity.

- Inpatient hospitalization may also be indicated for the initial few treatments for individuals with co-existing medical conditions that may seriously increase the risk of the procedure.
- For most individuals, ECT is generally safe and effective on an outpatient basis when there is no medical necessity for more restrictive levels of care.

Expectations for Electroconvulsive Therapy (ECT):

The initiation of ECT is preceded by certain assessments and procedures:

- A psychiatric evaluation that establishes that the diagnostic criteria are met for a condition that evidence has shown to be likely to positively respond to ECT.
- A medical assessment to evaluate for any medical conditions that might increase the risks associated with ECT or anesthesia, as well as an evaluation by a qualified nurse anesthetist or anesthesiologist to determine if there are any conditions that may indicate a need for special precautions.
- Education of the Individual and family about the procedure that includes disclosure of potential risks and benefits and that results in written, informed consent by the individual or legal guardian, with the understanding that such consent may be withdrawn at any time.
- The ECT procedure is administered by a psychiatrist who has participated in ongoing continuing education on ECT and who maintains all legally-required certifications.
- An assessment of currently prescribed medications has been completed, and if the individual is continuing to take certain medications that might possibly negatively impact the procedure (e.g., theophylline, lithium, benzodiazepines, and/or anticonvulsants), there is documentation of the clinical reasons for continuation of these medications.

Note: *If there is evidence of any of the following medical conditions, there needs to be documented evidence that the risks and benefits of ECT vs. other forms of treatment vs. no further treatment have been thoroughly considered and reviewed with the individual or guardian, and that the individual's condition requires a rapid, definitive response:*

- Unstable or severe cardiovascular disease
- Aneurysm or arteriovenous malformation
- Recent stroke
- Severe lung disease

- American Society of Anesthesiology physical status classification level Four or Five.

Criteria for Initiation of Treatment

All of the following must be met:

- All basic elements of medical necessity must be met.
- One or more of the following criteria must be met:**
 - The individual has a diagnosis of Major Depression, moderate or severe, or Mania, AND
 - Is resistant to treatment with medications, as evidenced by a lack of response to trials of at least three medications with adequate dose, duration and compliance to meet an expectation of improvement, OR
 - Is intolerant of the side effects or adverse effects of psychopharmacologic agents, or is unable to take such agents due to drug interactions with a medically necessary medication deemed to be less likely or less severe with ECT, OR
 - Experiences deterioration of a psychiatric condition that creates a need for a rapid, definitive response to ensure the safety of the individual, OR
 - Is experiencing a high degree of symptom severity and functional impairment.
 - OR
 - The individual has a diagnosis of a psychotic disorder with (one of the following):
 - Abrupt or recent onset of psychotic symptoms, OR
 - Catatonia, OR
 - A history of favorable response to ECT, OR
 - Experiences deterioration of a psychiatric condition that creates a need for a rapid, definitive response to ensure the safety of the individual, OR
 - Is experiencing a high degree of symptom severity and functional impairment.
- All of the following must be met:**
 - A medical evaluation has been completed to assess potential risks associated with ECT.
 - Risks and potential benefits of ECT have been explained and understood by the individual or guardian, and written, signed, informed consent has been obtained.
 - Where applicable state laws require it, a second opinion consultation has been completed. Second opinion

consultations should also be considered for women who are pregnant or for children/adolescents under age 18.

- There is no evidence of increased intracranial pressure (most commonly due to an inflammatory condition in or around the brain or spinal cord).

Criteria for Continuing Treatment with Electroconvulsive Therapy

1. All of the following must be met:

- The initial course of treatment consists of two to three treatments per week, generally on non-consecutive days. (Note: the frequency of treatments may be reduced if delirium or severe cognitive dysfunction occurs).
 - The number of treatments is a function of the individual's response, but should be in the range of 6 to 12 but not to exceed 20 sessions.
 - If there is no clinical improvement after 8-10 sessions, the potential benefits of continued ECT should be reassessed by the Attending Physician.
- Continuation ECT** (continuation of treatment for 6 months at intervals of 1 week or longer) may be indicated if both of the following are met:
 - The individual has responded well to ECT.
 - Interval psychiatric and medical evaluations are completed prior to each treatment,
 - Maintenance ECT** (continuation of treatment for longer than 6 months at intervals of 2 weeks or longer) is indicated if all of the following are met:
 - The individual has responded well to ECT.
 - Interval psychiatric and medical evaluations are completed prior to each treatment.
 - Frequency of sessions is at the minimum which sustains remission.
 - Continued need for Maintenance ECT is reassessed every 6 months.
 - Clinical treatment plans and consents are updated every six months.

Psychological/ Neuropsychological Testing

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health

care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (a) Required to meet the essential health needs of the patient;
- (b) Consistent with the diagnosis of the condition for which they are required;
- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Description - Psychological/ Neuropsychological Testing

is the use of one or more standardized measurements, instruments or procedures to assess intellectual/cognitive ability, psychopathology, psychiatric symptomatology, personality, interpersonal processes, behavioral functioning, and/or adaptive skills.

- May be used to guide differential diagnosis in the treatment of psychiatric disorders and to provide treatment recommendations.
- The use of validated psychological testing Instruments is considered adjunctive to other assessment tools that may include a face-to-face clinical interview, information gathering and review use of behavioral rating scales, consultation with collateral sources, and the individual's history.
- Psychological testing may be an appropriate adjunctive intervention when its use is expected to have a unique, specific, and direct impact on treatment outcome.

Note: Educational testing is not considered a medically necessary service under the behavioral health benefit.

- Educational testing is the use of psychological tests for educational purposes (e.g., to rule out a learning disability, determine learning style, and/or assess academic achievement), to provide support for an academic accommodations request, or for vocational purposes.
- Parents of children looking for educational testing are encouraged to check with their public school district for resources.

Psychological Testing In Alcohol and Drug Treatment

The individual's compromised cognitive functioning often confounds the results of psychological testing in the context of early treatment for alcohol and drug dependence. Therefore, there should be a minimum of 30 days abstinence prior to the administration of testing for a mood disorder, and a minimum of 90 days abstinence for the assessment of cognitive functioning/ impairment.

Expectations for Psychological/ Neuropsychological Testing:

- Psychological testing is to be conducted by a licensed psychologist (Ph.D., Psy.D. or Ed.D.).
- Neuropsychological testing is to be conducted by a licensed doctoral level psychologist (Ph.D. or Psy.D.) who has specialized training in the administration, scoring, and interpretation of neuropsychological instruments.
- Testing by a psychometrist is allowed when the psychometrist has received appropriate training and is working under the direct supervision of a licensed psychologist/neuropsychologist.
- When a psychometrist/psychological assistant are used, the psychologist/neuropsychologist must conduct the clinical interview and design the test battery before the psychometrist begins to administer any tests.
- When administration of psychological/neuropsychological testing is delegated to a psychometrist or psychological assistant, the report must be signed by the fully licensed psychologist or neuropsychologist who is responsible for the interpretation of test results.

Note: Psychological testing results for inpatient cases should be reported (at least informally) within 24-hours and for outpatient cases should be reported within one week.

Criteria for Medical Necessity

All of the following must be met:

1. Psychological/Neuropsychological Testing is expected to offer unique, specific and direct information regarding the development or monitoring of the treatment plan
2. **One or more of the following criteria must be met:**
 - A. A diagnosis cannot be made with information derived from a thorough clinical interview, behavioral observation, consultation with collateral sources of information, and a review of history, OR
 - B. Development of a treatment plan would be ineffective and/or inefficient without information that can only be obtained by psychological testing, OR

- C. The individual has undergone a course of psychological or psychiatric treatment and the response is not as expected from the treatment plan, OR
- D. To assist with the differential diagnosis of a psychiatric versus neurological or other medical diagnosis that may be associated with psychiatric symptoms.

Psychological/Neuropsychological Testing is generally NOT considered medically necessary when one (or more) of the following are present:

1. Other sources of the same information are available (e.g., clinical interview, behavioral observations or review of individual's history), OR
2. The diagnosis appears clear without testing (testing is not required to "validate" a diagnosis), OR
3. The results of testing would have no significant effect on the design and implementation of a treatment plan for a psychological disorder, OR
4. A diagnosis has already been rendered, and the individual has shown improvement via the treatment plan already in place. (e.g., individual's MD is currently prescribing medication for ADHD but wants testing to "validate" the diagnosis), OR
5. The rationale for testing is vague, or the diagnostic question lacks specificity (e.g., "Parents want to know what's going on," "The pediatrician is asking for it," "Just want to get a bigger picture."), OR
6. Testing appears to be primarily for educational purposes (e.g., to rule out a learning disability, determine learning style and/or assess academic achievement), to provide support for an academic "accommodations" request, or for vocational purposes, OR
7. The individual has a history of problematic drug or alcohol use/dependence and has not been able to demonstrate a sustained period of sobriety for 30 days prior to testing for a mood disorder/90 days when assessing cognitive functioning, OR
8. Testing is requested primarily for legal purposes including custody evaluations, parenting assessments, or other court or government ordered/requested testing AND the request does not otherwise meet the criteria for testing, OR
9. Testing is requested primarily for work-related concerns/return to work AND the request does not otherwise meet the criteria for testing, OR
10. Results of testing are used primarily for admission to a treatment facility AND the individual would not otherwise meet criteria for testing, OR
11. The requested test battery would not answer the referral question, OR
12. There is concern about the specific tests being requested:
 - A. The requested tests are outdated, OR
 - B. The reliability and validity for the requested tests are not established, OR
 - C. Appropriate normative data are not available for the requested tests.

Notes:

- *Psychological/neuropsychological testing may be managed by Cigna Behavioral Health, Cigna Health Care, or another non-Cigna health plan. Please refer to the applicable benefit plan document to determine the terms and conditions of coverage.*
- *Benefit Plan requirements may vary regarding preauthorization and review for psychological and neuropsychological testing. Please confirm the benefit plan requirements prior to rendering or receiving services.*
- *Cigna Coverage position #0258 Neuropsychological Testing clarifies diagnoses for which Cigna considers neuropsychological testing to be experimental, Investigational or unproven.*

Autism Behavior Intervention Therapies (ABIT)

In considering the appropriateness of any level of care, all basic elements of the Medical Necessity definition should be met:

Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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- (c) Consistent in type, frequency and duration of treatment with scientifically-based guidelines as determined by medical research;
- (d) Required for purposes other than the convenience of the provider or the comfort of the patient;
- (e) Rendered in the least intensive setting that is appropriate for the delivery of health care.

Note: Autism Behavior Intervention Therapies (also described as Early Intensive Behavior Interventions or Intensive Behavior Interventions) are excluded under many Cigna Behavioral Health benefit plans, but may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage. (Plans that do not have specific language for ABIT follow Cigna's Coverage Positions for coverage determinations.) Please refer to CIGNA's Coverage Positions for more information on individual therapies such as Applied Behavioral Analysis to treat Autism Spectrum Disorders.

Description – Autism Behavior Intervention Therapies (ABIT):

Autism Spectrum Disorders cause serious, lifelong impairments in behavior, cognition, and social development. Autism Behavioral Intervention Therapies (ABIT), such as Applied Behavioral Analysis, focuses on identifying behaviors that interfere with normal developmental processes, understanding the relationship between a behavior and the child's environment, and modifying those behaviors in such a way so as to improve the child's functional capacity. The three types of behaviors typically targeted for intervention are:

- Communication,
- Ability to develop social relationships,
- Repetitive restricted, stereotypic activity.

Expectations for Autism Behavior Intervention Therapies (ABIT):

- Prior to initial authorization of services, a full and comprehensive evaluation must be completed to determine if this type of treatment is medically necessary and clinically appropriate. .
- At a minimum, this evaluation must include:
 - Diagnosis of a condition on the Autism Spectrum (299 through 299.9), per the Diagnostic and Statistical Manual of Mental Disorders [DSM])
 - Developmental history and current functioning assessment completed by a developmental pediatrician, pediatric neurologist, psychologist, psychiatrist, or other licensed mental health professional. The evaluation should include a standard observational assessment tool, such as the Autism Diagnostic Observation Scale (ADOS), the Autism Diagnostic Interview (ADI), the Childhood Autism Rating Scale (CARS), or the Checklist for Autism in Toddlers (CHAT).

- Clearly stated recommendations for ABIT treatment, including the number of hours per day/week needed for the child to demonstrate functional improvement.
- A parent interview, school behavioral observation, physical examination, and a communications/speech evaluation may also be included in the evaluation process.
- These services may be provided at a location outside of the child's home or exclusively in the home, and are typically provided on a one-to-one basis by a behavioral clinician with specific behavior intervention training (e.g., a Board Certified Assistant Behavior Analyst (BCaBA), a Certified Assistant Behavior Analyst (BCaBA), an Independent Licensed Mental Health Provider, or a behavioral clinician supervised by a BCBA or Licensed Provider).
- Supervision is designed to assess quality of the program delivery, monitor progress, and make suggested changes. Often the supervisor comes to the child's home to observe directly, but in some instances, the consultant may conduct the supervision from videotapes made of the child during programming.
- Careful coordination with services offered through the school system is important to maximize effectiveness. Also, parent education, training, and involvement are critical to the overall success of an intervention program.

Criteria for Initiation of Treatment with ABIT

All of the following must be met:

1. All basic elements of medical necessity must be met.
2. A diagnosis of a condition on the Autism Spectrum (299 through 299.9, per the Diagnostic and Statistical Manual of Mental Disorders [DSM]) is present.
3. A full and comprehensive evaluation as noted above has been completed.
4. There is evidence from the evaluation that suggests the individual is capable of making behavioral and cognitive gains.
5. There is a comprehensive and individualized behavioral treatment plan that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improving those behaviors.
6. Treatment does not replace or interfere with educational services, if applicable.
7. The treatment plan includes a plan for the individual's parents to continue behavior interventions in the home environment.

Criteria for Continued Treatment

All of the following must be met:

1. The individual continues to meet all basic elements of medical necessity.
2. The individual's treatment plan has been updated to include addressing new behaviors and ensuring maintenance of acquired skills.
3. The individual's parents continue to have active participation as prescribed by the treatment plan.
4. There is evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of a reliable and valid assessment instrument (e.g., ABLLS).
5. The treatment program is coordinated with government mandated/school services as appropriate.



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