Appendix B  Medical Necessity Criteria

Purpose:

In order to promote consistent utilization management decisions, all utilization and care management staff and physician reviewers shall use MHNet's Medical Necessity Criteria unless different criteria are required for a specific account.

These medical necessity criteria are not intended to be construed or to serve as a standard of treatment. Standards of treatment are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These criteria should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case. The behavioral health professional, in light of the clinical data presented by the member, must make the ultimate judgment regarding a particular location of care or treatment modality.

Nor are these medical necessity criteria intended to replace sound clinical judgment or internal clinical guidance. When applying the criteria to an individual, case managers and medical directors must consider such factors as:

- Age of the member,
- Presence of co-morbidities,
- Complications,
- The progress of treatment,
- The psychosocial situation, and
- The home environment, when applicable.

Case managers and medical directors must also consider the characteristics of the local delivery system that are available for the member, such as:

- Availability of alternative levels of care,
- MHNet's or the health plan's coverage of benefits for alternative levels of care, and
- Ability of local providers to provide all recommended services within the anticipated length of stay.

MHNet also takes into account the benefit design as defined by the member’s certificate of coverage.
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GUIDELINES FOR INTERPRETING MHNET’S MEDICAL NECESSITY CRITERIA FOR ADOLESCENTS WHO’VE BEEN DESIGNATED AS SEX OFFENDERS

The term “sex offender” is a legal term, not a psychiatric condition. Adolescent sex offenders, in general, have engaged in behaviors with another individual that involve genital contact. Adolescent sex offenders can be grouped according to their age, their sex, the sex of the individual they have contact with, the age of the individual they have contact with (peer versus child), the degree of aggression involved and the act itself. The most common psychiatric diagnosis associated with adolescent sex offenders is conduct disorder. It is unclear if conduct disordered adolescents who act out sexually are significantly different from those who act out in a non-sexual manner. It is clear, however, that our society reacts much differently to acts that have a sexual connotation.

Since there is no specific psychiatric diagnosis that is associated with all adolescent sex offenders interventions designed to reduce recidivism are directed towards behavior modification and addressing stresses in the individual’s life that may be increasing the urge to re-offend. Stresses may derive from the family, an academic setting, peer relations and an underlying psychiatric condition.

Addressing the needs of an adolescent sex offender begins with a comprehensive outpatient evaluation. Admission to an inpatient unit would only be required if the individual is deemed to be an immediate danger to themselves or others. The outpatient evaluation should include details of the individual’s offense(s), their current legal status, their understanding and insight into the deviant behavior, their home situation including relationships with parents and siblings, their academic standing and their peer relationships. In addition there should be a comprehensive review of psychiatric symptoms to determine if the individual has a diagnosable psychiatric condition.

Following the initial evaluation a comprehensive treatment plan should be developed that includes individual, group and family therapy. The plan should be directed towards treating any underlying psychiatric condition, stabilizing the home environment and reducing the chances of re-offending (i.e. relapse prevention).
If there is an underlying psychiatric or substance abuse problem medical necessity criteria should be applied according to that condition. The level of care should be based on an assessment of the member’s safety, ability at self-care, reality construction, social functioning and complicating conditions. In this context, being designated a sex offender should be considered a complicating condition that needs to be factored into the decision, but is not, in and of itself a major determinant of level of care.

In the event that there has been a court order for treatment, this cannot be accepted in lieu of meeting medical necessity criteria.


Letourneau EJ, Miner MH: Juvenile sex offenders: a case against the legal and clinical status quo. Sexual Abuse: J Research Treatment 17(3):293-312, 2005


ADULT INPATIENT CARE

ADMISSION CRITERIA:

Admission to an adult psychiatric unit must be based on the following: Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to this level of care.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis, and
2. Patient's condition must be directly attributable to the designated mental disorder and not to Antisocial Personality or be a part of a pervasive pattern of antisocial conduct.
3. Alternatives at lower levels of care have been attempted or seriously considered, and
4. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement, and
5. Treatment at a lower level of care is not possible because the individual requires 24-hour continuous observation and/or treatment.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to inpatient psychiatric care as evidenced by one or more of the following:

Impairment in Safety: Patient presents an immediate risk of suicide or the patient presents a danger to others through assaultive or homicidal behavior.

Impairment in Self Care: Patient presents a temporary and reversible inability to perform personal hygiene and bodily care activities of daily living and there are attendant risks to that person's safety and well being.

Impairment in Reality Construction: Patient presents psychotic symptoms that must be controlled to prevent immediate risks to the patient or others.
Impairment in Social Functioning: Patient presents severely disruptive behavior that violates established social norms and/or violates the rights of others.

Complicating Conditions: Patient presents psychiatric condition that complicates medical care, medical conditions that complicate psychiatric care, or close observation is required to manage complications that may attend psychotropic medications or ECT.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

As further justification, the patient presents, with significant limitations in resources, to resolve presenting problems as indicated by:

Limited Personal Resources: Patient does not currently have the cognitive and/or emotional coping skills to reduce risks presented.

Limited Social Resources: Patient does not have adequate social support from family and/or friends to reduce risks presented.

Exclusion - Limitations in personal or social resources, in and of themselves, are not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

The patient should receive the following services to justify admission to this level of care:

1. A comprehensive, psychiatric assessment and initial treatment plan including a tentative discharge plan must be completed within 24 hours of admission.
2. There must be daily review of the treatment by a physician documented by the daily progress note.
3. Close supervision and observation aimed at evaluation of effects of psychotropic medications.
4. Observation and control measures (e.g., isolation or restraint) appropriate to risks to the patient or others.
5. Introduction of psychotropic medication appropriate to the higher risk symptoms presented.
6. Begin ECT, if ECT treatment justified admission to this level of care.
7. Multimodal plan of care requiring close medical supervision has been implemented.
8. Treatment and/or preventive measures to address complications of concern.
9. Intensive crisis intervention on an individual or group basis.
10. Intervention with the family of the patient to resolve crisis/emergent issues.

CONTINUED STAY CRITERIA:

In order to justify remaining in an adult inpatient unit the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and one or more of the following:

1. Intensity of service being delivered should be appropriate to the risk level that justified the admission.
2. Continued evidence of symptoms reflecting significant risk to the patient or others (e.g., suicide).
3. Complications arising from initiation of, or change in, medications or ECT.
4. Need for continued close observation in regulation of higher risk psychotropic medications.
5. Persistence of higher risk psychotic symptoms such that continued close observation and control is required.
6. Increased risk of complications as a result of intervention or as a product of newly discovered conditions.
7. While progress reinforces the judgement that the disability is temporary and not chronic. These are considered temporary disability.
8. Effective discharge planning has begun and additional days will reduce the probability of a re-hospitalization.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:

a) They complete the treatment plan.

b) Their impairment in functioning no longer requires 24 hour observation or treatment.

c) The patient leaves against medical advice (AMA).

The patient refuses treatment and/or the problem(s) that prompted admission are found to be refractory or chronic. Disposition under these circumstances must be predicated on assuring the patients safety, applicable state law, as well as the health plan benefit.
ADULT REHABILITATION UNIT FOR
SUBLANCE-RELATED DISORDERS

PROGRAM DESCRIPTION:

Substance abuse rehabilitation units provide medical and/or psychiatric stabilization to individuals who are withdrawing from drugs or alcohol. They must be capable of providing medically monitored detoxification services as well a psychiatric assessment and interventions.

ADMISSION CRITERIA:

Admission to a rehabilitation unit for a substance-related disorder must be based on the following: Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to a rehabilitation unit.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis of substance dependence, and

2. Patient's condition must be directly attributable to a substance-related disorder and not to Antisocial Personality or be a part of a pervasive pattern of antisocial conduct.

3. Patient is in need of specialized treatment (medically monitored detoxification or psychiatric stabilization) before being treated in a residential or outpatient substance abuse treatment program.

4. Alternative levels and locations of care, such as partial hospitalization have been deemed to place patient at significant risk for deterioration, injury or permanent disability.

5. Specialized intervention is considered likely to be effective and to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to a rehabilitation facility as evidenced by one or more of the following:
Impairment in Safety: Patient presents risks of danger to themselves through suicide or a danger to others as a result of assaultive or homicidal behavior and such risk can be reduced through rehabilitative hospitalization and/or patient is at risk for serious medical complications if they are detoxified in a non-medical setting or they have an unstable medical condition that requires medical supervision.

Impairment in Self Care: Substance dependency is such that capacity for essential self care has been temporarily diminished in a way that imposes immediate risk to the patient and the attendant risks can be reduced with rehabilitative hospitalization.

Impairment in Reality Construction: Patient presents significantly diminished ability to obtain essential information from the environment, to problem solve effectively and to respond to treatment efforts at lower levels of care (e.g., outpatient).

Impairment in Social Functioning: Pattern of dependence has seriously impaired the patient's social, family and occupational functioning, there is a reasonable expectation that significant functioning can be restored with rehabilitative hospitalization and that such functioning is unlikely to be restored without rehabilitative hospitalization.

Complicating Conditions: Patient presents co-morbid conditions that substantially complicate outpatient care or medical complications that can be resolved only through a period of rehabilitative hospitalization.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

Patient presents with significant limitations in resources to resolve presenting problems as indicated by:

Limited Personal Resources: Patient does not currently possess coping skills that permit resolution of depending problems on an outpatient basis.

Limited Social Resources: Patient lacks support from family or significant others that could provide the essential context for outpatient success.

Exclusion - Limitations in personal or social resources, in and of themselves, are not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

Within this rehabilitative setting the patient should be receiving the following services as further justification of the admission:

1. Crisis oriented services to reduce risks that justified the admission (e.g., suicidality).
2. Individualized plan of care that recognizes unique characteristics, problems and motivations.

3. Medical interventions appropriate to any detoxification risks and/or physical complications that attend the patient's dependency.

4. Treatment plan focuses directly on abstinence from the substance or substances of concern.

5. Discharge planning within 24 hours of admission.

6. Co-morbid conditions identified and treated when appropriate (e.g., significant depression).

7. Program provides for transition to outpatient support groups (e.g., AA or NA) that can reduce relapse probability.


CONTINUED STAY CRITERIA:

In order to justify remaining in a rehabilitative unit the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Intensity of service is appropriate to the level of care expected of a rehabilitation unit.

2. High-risk symptoms that justified the admission continue to manifest themselves (e.g., suicide).

3. Complications associated with withdrawal or other medical complications have presented themselves and are being treated by appropriate medical staff.

4. Patient is cooperating with the treatment team and is giving evidence of motivation to address dependency issues.

5. Patient continues to be unable to perform activities of daily living essential for maintaining safety.

6. Additional time in the rehabilitation unit is likely to reduce the risk of relapse and return to a hospital or rehabilitation setting.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:

a) They complete the treatment plan.

b) Their impairment in functioning no longer requires 24 hour observation or treatment.

c) The patient leaves AMA.
d) The patient refuses treatment and/or the problem(s) that prompted admission are found to be refractory or chronic. Disposition under these circumstances must be predicated on assuring the patients safety, applicable state law, as well as the health plan benefit.
CHILD & ADOLESCENT INPATIENT CARE

ADMISSION CRITERIA:

Admission to a hospital specializing in children and teens must be based on the following: Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and Intensity of Intervention appropriate to inpatient care. Laws regulating treatment of a minor are observed. Patients for whom there is no reasonable expectation that acute hospitalization will lead to a stable outpatient treatment program are excluded from admission. In addition, all admission decisions must be predicated on respect for the patient’s autonomy by providing treatment in the least restrictive setting.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis, other than Conduct Disorder, and

2. Patient's condition must be directly attributable to the designated mental disorder and not a part of a pervasive pattern of antisocial conduct.

3. Alternative outpatient care has been attempted or seriously considered, and

4. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to hospital care as evidenced by one or more of the following:

Impairment in Safety: Patient presents significant risk of suicide, immediate risk of harm to others (e.g., assault or homicide), or high risk behavior that places the patient or others in danger.

Impairment in Self Care: Temporary and reversible disability of the patient to perform personal hygiene and bodily care activities of daily living without which risk obtains.

Impairment in Reality Construction: Patient presents psychotic symptoms that lend themselves to acute intervention and which place the person, or others, at risk.

Impairment in Social Functioning: Patient presents severe deficits in social functioning at school, home and/or in the community and this condition can improve with acute
hospitalization. Impairment of social functioning in the absence of severe impairment in one or more of the above indicators does not justify hospitalization.

**Complicating Conditions:** Patient presents medical conditions that complicate psychiatric treatment, psychiatric symptoms that complicate medical care, or patient requires intensive observation to manage potential complications that attend a planned medication regime.

**LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:**

As further evidence for acute care, the patient presents with significant limitations in resources to resolve presenting problems as indicated by:

**Limited Personal Resources:** Patient does not have the coping skills sufficient to reduce risk without this level of service.

**Limited Social Resources:** Patient does not have the family and/or the social support needed to reduce level of risk without this level of service.

**Exclusion** - Limitations in resources, in and of themselves, are not sufficient justification for admission.

**INTENSITY OF SERVICE ELEMENTS:**

Within inpatient care, the patient should be receiving the following services as further justification of the admission:

1. Precautions (e.g., frequency of observation) appropriate to the risk level that justified the admission.
2. Intensive crisis intervention and appropriate family involvement.
3. Psychiatric assessment within 24 hours of admission and psychotropic medications ordered.
4. Active discharge planning with resolution of follow up placement issues within 24 hours of admission.
5. Family system and its contribution to the current crisis evaluated.
7. Efforts to resolve any temporary disability that justified hospital care.

**CONTINUED STAY CRITERIA:**
In order to justify remaining in hospital setting the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and one or more of the following:

1. Intensity of service being provided is appropriate to level of risk currently being presented.
2. Continued risk to self or others is manifest in the patient's current behavior.
3. Continued close supervision and monitoring is essential given risks that attend prescribed psychotropic medications.
4. Complications have been identified or have arisen as a result of planned intervention.
5. Continued temporary disability in key areas of daily living and initial signs of success at reversing the temporary disability.
6. Persistence of psychotic symptoms, which would place the patient at risk if discharged.
7. Placement problems that put the patient or others at risk and which can be resolved within two days.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when they satisfy any of the following criteria:

a) They complete the treatment plan.
b) Their impairment in functioning no longer requires 24 hour observation or treatment.
c) The patient refuses treatment and/or the problem(s) that prompted admission are found to be refractory or chronic. Disposition under these circumstances must be predicated on assuring the patients safety, applicable state law, as well as the health plan benefit.
d) At the time of discharge, the parents are legally responsible for the patient.
CHILD & ADOLESCENT REHABILITATION FACILITY

ADMISSION CRITERIA:
Admission to a child and adolescent substance abuse rehabilitation facility must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and Intensity of Intervention appropriate to a rehabilitation facility.

GLOBAL INDICATORS:
1. Patient meets DSM-IV criteria for substance dependency, and
2. Patient's condition must be directly attributable to the designated mental disorder and not be a part of a pervasive pattern of antisocial conduct.
3. Alternative outpatient care has been attempted or seriously considered, and
4. Professional intervention is essential to contain risks, and
5. Patients with intractable substance abuse unlikely to maintain sobriety post discharge are excluded.

SEVERITY OF ILLNESS:
An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to a rehabilitative facility as evidenced by one or more of the following:

Impairment in Safety: Patient presents as a risk to themselves though suicide or a danger to others as a product of assaultive or homicidal behavior and such impairment is considered a product of substance dependency.

Impairment in Self-Care: Dependency is such that the patient is temporarily unable to perform essential activities of daily living that maintain safety from immediate harm.

Impairment in Reality Construction: As a direct product of substance dependency the patient has significantly diminished ability to accurately perceive reality and to exercise appropriate judgment.

Impairment in Social Functioning: Use of substances has resulted in significant impairment in family, social and educational functioning unlikely to be remedied without a 24 hour rehabilitation program.

Complicating Conditions: Patient presents comorbid conditions that substantially complicate outpatient care or medical complications that can be resolved only through a period of rehabilitative hospitalization.
LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

As further evidence for hospital care the patient presents with significant limitations in resources to resolve presenting problems as indicated by:

**Limited Personal Resources:** Patient has not learned those coping skills essential to resolution of dependency on an outpatient basis.

**Limited Social Resources:** Patient lacks the level of parental support or prosocial peer support to provide the context for outpatient success.

**Exclusions** - Limitations in resources, in and of themselves, are not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

Within an inpatient rehabilitation setting the patient should be receiving the following services as further justification of the admission:

1. Family education and involvement.
2. Crisis services to reduce risks that justified the admission (e.g., suicidality).
3. Individualized plan of care that includes discharge placement and follow up care.
4. Medical interventions appropriate to risks.
5. Plan of care with elements that focus directly on abstinence from the substance, or substances, of concern.
6. Discharge planning within 24 hours of admission.
7. Co-morbid conditions actively addressed (e.g., conduct problems) in intervention.

CONTINUED STAY CRITERIA:

In order to justify remaining in a child and adolescent rehabilitation unit the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Intensity of service is appropriate to the level of care expected of a rehabilitation unit.
2. Higher risk symptoms that justified the admission continue to manifest themselves (e.g., suicide risk).
3. Complications associated with withdrawal or other medical complications have presented themselves and are being treated by appropriate medical staff.
4. Both the patient and the family are cooperating fully with the treatment team.
5. Patient continues to be unable to perform activities of daily living essential for the maintaining safety.
6. Additional time in the rehabilitation unit is likely to reduce the risk of relapse and return to a hospital or rehabilitation setting.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:
   a) They complete the treatment plan.
   b) Their impairment in functioning no longer requires 24-hour observation or treatment.
   c) The patient leaves AMA.
   d) The patient refuses treatment and/or the problem(s) that prompted admission are found to be refractory or chronic. Disposition under these circumstances must be predicated on assuring the patient’s safety, applicable state law, as well as the health plan benefit.
RESIDENTIAL TREATMENT FOR ADULTS - PSYCHIATRIC

PROGRAM DEFINITION:

To qualify as a residential program the patient must be in a structured environment and be medically monitored, with 24-hour medical availability, 24-hour on-site nursing services and 24-hour 7-days-week supervision. This care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. A multidisciplinary treatment team (i.e., physicians, psychologists and therapists) must administer treatment. The treatment day consists of at least 7 hours of structured activity with at least 4 hours in individual and/or group therapy. The patient must participate in treatment daily. The patient’s family, if applicable, must be actively involved in treatment at least 1 to 2 times per week.

Treatment must be for the psychiatric condition. This level of care excludes custodial care, respite for the family, or legal problems and is not appropriate for the sole purpose of preventing relapse. Treatment for antisocial behavior is not a DSM-IV Axis I diagnosis and is amendable to short term interventions and is not a basis for residential care.

ADMISSION CRITERIA:

1. Patient presents at least one valid DSM-IV Axis I diagnosis that is reasonably expected to improve as a result of psychiatric treatment.

2. Behavior that supports non-life threatening emergent care is indicative that risk of suicide, assaultive, or homicidal behavior would be present at a lower level of care.

3. Patient is medically stable and not bed confined or has no medical complications that would prevent participation in residential care.

4. Patient has severe limitations or impairment in their family and other social support systems and consequently an alternative more structured environment is required for substantial improvement in the patient's condition.

5. Patient has the cognitive ability to understand and process in both individual and group therapy modalities.

6. Patient has the emotional stability to participate in both individual and group therapies.

7. Patient has the capacity to develop and implement skills and strategies that will enable them to learn skills to function more independently.

Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for admission.
GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis that is amenable to psychiatric treatment and failure to admit to this level of care is likely to result in significant psychological or social impairment which would require inpatient treatment for stabilization, and

2. Alternative levels of care such as traditional and/or intensive outpatient therapy, and partial hospitalization have been attempted or seriously considered and relapse has occurred within six months of the patient’s active participation in such treatment.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to residential care as evidenced by the following:

**Impairment in Safety:** Presents a pervasive pattern of poor impulse control and high-risk behavior, assaultive or homicidal behavior and periods when the risk of harm to self or harm to others is considered high.

**Impairment in Self-Care:** Presents significant impairment in capacity for self care without being monitored in a highly structured environment and as such, presents potential harm to self.

**Impairment in Reality Construction:** Presents mild impairment in cognitive and perceptual function and attendant impairment in judgment and problem solving and as such, presents potential harm to self or others.

**Impairment in Social Functioning:** Presents disturbances in age-appropriate adaptive functioning and interpersonal functioning manifested in the family, at work and other social settings and as such presents potential harm to self or others.

**Complicating Conditions:** Physiological complications are minimal, coexisting medical problems will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.

INTENSITY OF SERVICE ELEMENTS:

Within residential care, the patient should be receiving the following services as further justification of the admission:

1. A multidisciplinary assessment of social, psychological, and developmental and biological functioning.
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2. An evaluation by a psychiatrist occurs within the first 24 hours of the admission and is followed by visits from the attending psychiatrist at least two times per week.

3. A comprehensive treatment plan with specific measurable goals, timelines for achievement of those goals and methods of intervention.

4. The treatment plan includes a discharge plan, which is initiated within the first 24 hours of treatment. The discharge plan shall include active participation of the patient/family and specify long term placement if necessary.

5. The family system is the subject of assessment and the family is actively involved in treatment.

6. A structured environment which provides the patient with systematic feedback regarding progress or lack of progress toward treatment goals.

7. Vocational and independent living skills training are addressed in the program when age appropriate and/or applicable to permanent placement goals.

8. Focused group therapy that addresses goals identified in the plan of care.

9. Treatment plan includes methods and/or goals for addressing crisis management.

CONTINUED STAY CRITERIA:

In order to justify remaining in residential treatment the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Psychological disturbances continue to significantly impair level of functioning.

2. Persistence of problems that caused the admission to a degree that continued to meet the admission

3. Patient and the patient's family are actively participating in the treatment process.

DISCHARGE CRITERIA:

The patient is ready for discharge when any of the following are obtained:

a) Patient no longer meets criteria for continued stay.

b) Patient can sustain progress and resolve remaining treatment goals in a less restrictive environment. (i.e., IOP, traditional outpatient services).

c) Patient has deteriorated and needs to be admitted to a higher level of care.

d) Patient has not engaged in treatment and further progress is unlikely.

e) During the course of treatment it is determined that the patient has a psychiatric disorder that is not amenable to structured psychiatric care.

f) Patient leaves AMA.
RESIDENTIAL TREATMENT FOR ADULTS – SUBSTANCE ABUSE

PROGRAM DEFINITION:

To qualify as a residential program the patient must be in a structured environment and be medically monitored to manage a patient's ancillary detoxification needs, with 24-hour medical availability, 24-hour on-site nursing services and 24– hours a day, 7-days-week supervision. This care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. A multidisciplinary treatment team (i.e., physicians, psychologists and therapists) must administer treatment. The treatment day consists of at least 7 hours of structured activity with at least 4 hours in individual and/or group therapy. The patient must participate in treatment daily. The patient’s family, if applicable, must be actively involved in treatment at least 1 to 2 times per week.

Treatment must be for substance abuse and dependence. This level of care excludes custodial care, respite for the family, or legal problems and is not appropriate for the sole purpose of preventing relapse. Treatment at this level of care is not appropriate when the sole purpose of treatment is due to the patient’s lack of compliance at a lower level of care or as a substitute for focused ambulatory treatment of relapse.

ADMISSION CRITERIA:

1. Patient presents at least one valid DSM-IV Axis I diagnosis of substance dependence.
2. Patient is medically stable and not bed confined or has no medical complications that would prevent participation in residential care.
3. Risk of exacerbation of serious concomitant medical complications due to continued substance abuse, which prohibits treatment from occurring safely at a lower level of care and requires 24-hour monitoring.
4. Risk of withdrawal symptoms, which cannot be safely monitored at a lower level of care.
5. Patient has severe limitations or impairment in their family and other social support systems and consequently an alternative, more structured environment is required for substantial improvement in the patient's condition.
6. Patient has the motivation and emotional stability to participate in both individual and group therapies.
7. Patient has the capacity to develop and implement skills and strategies that will enable them to learn skills to function more independently.
Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for admission.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis that is amenable to substance abuse treatment, and failure to admit to this level of care is likely to result in significant risk of harm to self which would require inpatient treatment for stabilization, and
2. Alternative levels of care such as traditional and/or intensive outpatient therapy, and partial hospitalization have been attempted or seriously considered, and relapse has occurred within six months of the patient’s active participation in such treatment.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to residential care as evidenced by the following:

Impairment in Safety: Patient presents risk of danger to themselves through suicide or danger to others through assaulitive or homicidal behavior and periods when harm to self or others risk is considered high.

Impairment in Self-Care: Patient presents significant impairment in capacity for self care without being monitored in a highly structured environment due to substance dependency and as such, presents potential harm to self.

Impairment in Reality Construction: Patient presents significantly diminished ability to obtain essential information from the environment, to problem solve effectively and to respond to treatment efforts at lower levels of care (i.e., outpatient).

Impairment in Social Functioning: Pattern of dependence has seriously impaired the patient’s social, family and occupational functioning, there is a reasonable expectation that significant functioning can be restored with residential treatment and that such functioning is unlikely to be restored through treatment at a lower level of care.

Complicating Conditions: Physiological complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.
INTENSITY OF SERVICE ELEMENTS:

Within residential care, the patient should be receiving the following services as further justification of the admission:

1. A multidisciplinary assessment of social, psychological, and developmental and biological functioning.

2. A comprehensive medical examination including history, physical examination and laboratory testing within the first 24 hours of the admission for those clients who did not have them done immediately prior to admission.

3. An evaluation by a psychiatrist occurs within the first 24 hours of the admission and is followed by visits from the attending psychiatrist at least two times per week.

4. A comprehensive treatment plan of behavioral health treatment and residential living support with specific measurable goals, timelines for achievement of those goals and methods of intervention.

5. Comprehensive treatment plan includes a discharge plan, which is initiated within the first 24 hours of treatment. The discharge plan shall include active participation of the patient/family and specify long term placement if necessary.

6. The family system is the subject of assessment, and the family is actively involved in treatment.

7. A structured environment which provides the patient with systematic feedback regarding progress or lack of progress toward treatment goals.

8. Vocational and independent living skills training are addressed in the program when age appropriate and/or applicable to permanent placement goals.

9. Focused group therapy that addresses goals identified in the plan of care.

10. Treatment plan includes methods and/or goals for addressing crisis management and relapse prevention.

CONTINUED STAY CRITERIA:

In order to justify remaining in residential treatment, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Persistence of problems that caused the admission to a degree that continued to meet the admission.

2. Patient and the patient's family are actively participating in the treatment process.
3. Patient continues to be unable to perform activities of daily living essential to maintaining safety.

4. The current or revised treatment plan includes a linkage and/or coordination with the available structured and supportive community based resources with the goal of returning to his/her regular social environment as soon as possible, when appropriate.

5. The current or revised treatment plan can be reasonable expected to bring about significant improvement in the problems that caused the admission and the patient’s progress is documented at least three times per week. The treatment includes a plan for discharge.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when any of the following are obtained:

- a) Patient no longer meets criteria for continued stay.
- b) Patient can sustain progress and resolve remaining treatment goals in a less restrictive environment (i.e., IOP, traditional outpatient services).
- c) Patient has deteriorated and needs to be admitted to a higher level of care.
- d) Patient has not engaged in treatment and further progress is unlikely.
- e) Patient leaves AMA.
RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS - PSYCHIATRIC

PROGRAM DEFINITION:

To qualify as a residential program the patient must be in a structured environment and be medically monitored, with 24-hour medical availability, 24-hour on-site nursing services and 24-hours-a-day, 7-days-week supervision. This care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. A multidisciplinary treatment team (i.e., physicians, psychologists and therapists) must administer treatment. The treatment day consists of at least 7 hours of structured activity with at least 4 hours in individual and/or group therapy. The patient must participate in treatment daily. The patient’s family, if applicable, must be actively involved in treatment at least 1 to 2 times per week.

Treatment must be for the psychiatric condition. This level of care excludes custodial care, respite for the family or legal problems and is not appropriate for the sole purpose of preventing relapse. Treatment for antisocial behavior is not a DSM-IV Axis I diagnosis and is amendable to short term interventions and is not a basis for residential care.

ADMISSION CRITERIA:

1. Patient may present developmental delays in capacity for self-regulation of affective experience and behavior.
2. Patient has severe limitations or impairment in their family and other social support systems; consequently, an alternative environment is required for substantial improvement in the patient's condition.
3. Patient has the cognitive ability to understand and process in both individual and group therapy modalities.
4. Patient has the emotional stability to participate in both individual and group therapies.
5. Patient has the capacity to develop and implement skills and strategies that will enable them to learn skills to function more independently.

Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for admission.

GLOBAL INDICATORS:
MHNet
Utilization Improvement Manual

1. Patient presents at least one valid DSM-IV Axis I diagnosis, and failure to admit to this level of care is likely to result in significant psychological impairment which would require inpatient treatment for stabilization, and

2. Patient's condition must be directly attributable to the designated mental disorder and not be a part of a pervasive pattern of behavioral and or conduct disorders, and

3. Alternative levels of care such as traditional and/or intensive outpatient therapy, and partial hospitalization have been attempted or seriously considered, and relapse has occurred within six months of the patient’s active participation in such treatment.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to residential care as evidenced by the following:

Impairment in Safety: Presents a pervasive pattern of poor impulse control and high-risk behavior, assaultive or homicidal behavior and periods when suicide or homicide risk is considered high.

Impairment in Self-Care: Presents significant impairment in capacity for self care without being monitored in a highly structured environment.

Impairment in Reality Construction: Presents mild impairment in cognitive and perceptual function and attendant impairment in judgment and problem solving.

Impairment in Social Functioning: Presents disturbances in age-appropriate adaptive functioning and interpersonal functioning manifested in the family, at school and other social settings.

Complicating Conditions: Physiological complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.

INTENSITY OF SERVICE ELEMENTS:

Within residential care, the patient should be receiving the following services as further justification of the admission:

1. A multidisciplinary assessment of social, psychological, and developmental and biological functioning.

2. An evaluation by a psychiatrist occurs within the first 24 hours of the admission and is followed by visits from the attending psychiatrist at least one time per week.
3. A comprehensive treatment plan with specific measurable goals, timelines for achievement of those goals and methods of intervention.

4. The comprehensive treatment plan includes discharge plan, which specifies long term placement.

5. The family system is the subject of assessment, and the family is actively involved in treatment.

6. A structured environment which provides the patient with systematic feedback regarding progress or lack of progress toward treatment goals.

7. Psychoeducational assessment with any identified needs being addressed in the educational component of the program including aftercare planning with the school system.

8. Vocational and independent living skills training are addressed in the program when age appropriate and/or applicable to permanent placement goals.

9. Focused group therapy that addresses goals identified in the plan of care.

10. Treatment plan includes methods and/or goals for addressing crisis management.

CONTINUED STAY CRITERIA:

In order to justify remaining in residential treatment the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Psychological disturbances continue to significantly impair level of functioning.

2. Progress is evident towards treatment goals. However, more consistency is needed to achieve treatment goals.

3. Patient and the patient's family are cooperating with the treatment process.

4. Behavior is indicative that risk of suicide, assaultive, or homicidal behavior would be present at a lower level of care.

5. During a period of transition to a permanent placement, the patient failed to sustain progress made in the residential setting.

6. Continued authorization of residential care will significantly reduce the likelihood of recidivism.

DISCHARGE CRITERIA:

The patient is ready for discharge when any of the following are obtained:

a) Patient no longer meets criteria for continued stay.

b) Patient can sustain progress and resolve remaining treatment goals in a less restrictive environment (i.e., IOP, traditional outpatient services).

c) Patient has deteriorated and needs to be admitted to a higher level of care.
d) Patient has not engaged in treatment and further progress is unlikely.

e) During the course of treatment it is determined that the patient has a psychiatric disorder that is not amenable to structured psychiatric care.

f) Patient leaves AMA.
RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS – SUBSTANCE ABUSE

PROGRAM DEFINITION:

To qualify as a residential program, the patient must be in a structured environment and be medically monitored to manage a patient’s ancillary detoxification needs, with 24-hour medical availability, 24-hour on-site nursing services and 24-hours-a-day, 7-days-week supervision. This care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. A multidisciplinary treatment team (i.e., physicians, psychologists and therapists) must administer treatment. The treatment day consists of at least 7 hours of structured activity with at least 4 hours in individual and/or group therapy. The patient must participate in treatment daily. The patient’s family if applicable must be actively involved in treatment at least 1 to 2 times per week.

Treatment must be for substance abuse and dependence. This level of care excludes custodial care, respite for the family or legal problems and is not appropriate for the sole purpose of preventing relapse. Treatment at this level of care is not appropriate when the sole purpose of treatment is due to the patient’s lack of compliance at a lower level of care or as a substitute for focused ambulatory treatment of relapse.

ADMISSION CRITERIA:

1. Patient presents a with a primary DSM-IV Axis I diagnosis of substance dependence
2. Patient is medically stable and not bed confined or has no medical complications that would prevent participation in residential care.
3. Risk of exacerbation of serious concomitant medical complications due to continued substance abuse, which prohibits treatment from occurring safely at a lower level of care and requires 24-hour monitoring.
4. Risk of withdrawal symptoms, which cannot be safely monitored at a lower level of care.
5. Patient has severe limitations or impairment in their family and other social support systems and consequently an alternative more structured environment is required for substantial improvement in the patient’s condition.
6. Patient has the motivation and emotional stability to participate in both individual and group therapies.
7. Patient has the capacity to develop and implement skills and strategies that will enable them to learn skills to function more independently.
8. The Patient is at risk of serious injury or death as a result of continued use.
Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for admission.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis that is amenable to substance abuse treatment and failure to admit to this level of care is likely to result in significant risk of harm to self, which would require inpatient treatment for stabilization, and

2. Alternative levels of care such as traditional and/or intensive outpatient therapy, and/or partial hospitalization have been attempted or seriously considered, and relapse has occurred within six months of the patient’s active participation in such treatment.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to residential care as evidenced by the following:

Impairment in Safety: Patient presents risk of danger to themselves through suicide or danger to others through assultive or homicidal behavior and periods when harm to self or others risk is considered high.

Impairment in Self-Care: Patient presents significant impairment in capacity for self care without being monitored in a highly structured environment due to substance dependency and, as such, presents potential harm to self.

Impairment in Reality Construction: Patient presents significantly diminished ability to obtain essential information from the environment, to problem solve effectively and to respond to treatment efforts at lower levels of care (i.e., outpatient).

Impairment in Social Functioning: Pattern of dependence has seriously impaired the patient’s social, family and occupational functioning, there is a reasonable expectation that significant functioning can be restored with residential treatment and that such functioning is unlikely to be restored through treatment at a lower level of care.

Complicating Conditions: Physiological complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.
INTENSITY OF SERVICE ELEMENTS:

Within residential care, the patient should be receiving the following services as further justification of the admission:

1. A multidisciplinary assessment of social, psychological, developmental and biological functioning.

2. A comprehensive medical examination including history, physical examination and laboratory testing within the first 24 hours of the admission for those clients who did not have them done immediately prior to admission.

3. An evaluation by a psychiatrist occurs within the first 24 hours of the admission and is followed by visits from the attending psychiatrist at least one time per week, with 24 hour psychiatric availability.

4. A comprehensive treatment plan of behavioral health treatment and residential living support with specific measurable goals, timelines for achievement of those goals and methods of intervention.

5. The comprehensive treatment plan includes a discharge plan, which is initiated within the first 24 hours of treatment. The discharge plan shall include active participation of the patient/family and specify long term placement if necessary.

6. The family system is the subject of assessment. The family is actively involved in treatment and the first family session occurs within the first 3 days of admission, followed by family sessions at least 2 times per week.

7. A structured environment, which provides the patient with systematic feedback regarding progress or lack of progress toward treatment goals.

8. Educational, vocational and independent living skills training are addressed in the program when age appropriate and/or applicable to permanent placement goals. The facility must abide by state laws in regards to educational requirements.

9. Focused group therapy that addresses goals identified in the plan of care.

10. Treatment plan includes methods and/or goals for addressing crisis management and relapse prevention.

CONTINUED STAY CRITERIA:

In order to justify remaining in residential treatment, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Persistence of problems that caused the admission to a degree that continued to meet the admission.

2. Patient and the patient's family are actively participating in the treatment process at least 2 times per week.
3. Patient continues to be unable to perform activities of daily living essential to maintaining safety.

4. The current or revised treatment plan includes a linkage and/or coordination with the available structured and supportive community based resources with the goal of returning to his/her regular social environment as soon as possible, when appropriate.

5. The current or revised treatment plan can be reasonable expected to bring about significant improvement in the problems that caused the admission, and the patient’s progress is documented on a daily basis. The treatment plan is updated weekly and includes a plan for discharge.

DISCHARGE CRITERIA:

The patient is ready for discharge when any of the following are obtained:

a) Patient no longer meets criteria for continued stay.

b) Patient can sustain progress and resolve remaining treatment goals in a less restrictive environment (i.e., IOP, traditional outpatient services).

c) Patient has deteriorated and needs to be admitted to a higher level of care.

d) Patient has not engaged in treatment and further progress is unlikely.

e) Patient leaves AMA.
EATING DISORDERS
ANOREXIA NERVOSA VERSUS BULEMIA NERVOSA

INTRODUCTION:

There are two separate and distinct eating disorders, Anorexia Nervosa and Bulimia Nervosa. Anorexia nervosa is potentially life-threatening and requires an aggressive multi-disciplinary approach. Bulimia nervosa can be mild to severe. Invariably it can be treated with outpatient cognitive behavioral treatment supplemented with supportive group therapy and possibly medications. There are numerous residential treatment settings to help people develop healthy eating habits catering to individuals with obesity as well as Bulimia Nervosa. They are not considered to be medically based treatment facilities; and therefore, would not qualify for reimbursement under health insurance.

Treatment of eating disorders requires therapists with specialized training. The treatment of Anorexia Nervosa requires a multi-disciplinary treatment approach. Treatment settings include inpatient, partial, IOP and outpatient. In the absence of a co-morbid condition, Bulimia Nervosa can be treated with individual and group outpatient therapy. Therefore, Medical Necessity Criteria for outpatient treatment can be applied as long as the therapist has specialty training in the treatment of Bulimia Nervosa.

ANOREXIA NERVOSA

DIAGNOSIS AND CARDINAL FEATURES:

1. Excessive thinness (15% below ideal body weight).
2. Distorted body image (experiences oneself as overweight).
3. Intense fear of gaining weight or becoming obese.
4. Weight control through restricting (doesn’t eat), exercise (burning off calories) and/or purging (inducing vomiting or diarrhea).

TREATMENT GOALS:

1. Stop weight loss.
2. Facilitate gradual return to normal body weight.
3. Retrain to healthy eating habits.
4. Avoid relapse.

TREATMENT APPROACH:

The effective treatment of Anorexia Nervosa mandates a coordinated interdisciplinary approach. Effective treatment must include:
1. An internist/pediatrician to address medical concerns.

2. A dietician to establish a healthy diet.

3. Individual and family therapy.

4. A psychiatrist to address co-morbid conditions (e.g., depression) and possible use of medications.

TREATMENT CRITERIA FOR ANOREXIA NERVOSA:

Admission to all levels of care for Anorexia Nervosa must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources.

GLOBAL INDICATORS:

1. Patient meets DSM-IV Axis I criteria for Anorexia Nervosa, and

2. Specialized intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

The level of care provided is dependent on an assessment of patient risk (need for safety) and the patient’s personal resources.

Impairment in Safety: The patient should be managed at the lowest level of care where safety can be managed. In the absence of a co-morbid condition safety, is defined as the ability to maintain and/or increase weight.

Impairment in Self-Care: The patient should be managed at the lowest level of care where the patient can be reasonably expected to be able to participate.

Impairment in Reality Construction: Impairment in reality construction (excluding distorted body image), in the absence of a co-morbid condition, generally indicates severe medical compromise and the need for inpatient or partial hospitalization. The patient must be sufficiently intact to benefit from individual and group therapy once the acute medical condition is resolved.

Limited Personal Resources: Lack of personal resources may require a higher level of care on a short-term basis to stabilize the patient’s living situation. Otherwise it is not generally a factor in level of care decisions.
Limited Social Resources: Lack of social resources in and of itself does not impact level of care decisions except as noted above.

SERVICE ELEMENTS FOR EACH LEVEL OF CARE:

INPATIENT TREATMENT:

Inpatient treatment should be conducted on units with specialty programs for eating disorders. The programs must include:

1. A behavioral approach to developing healthy eating habits with a primary focus on weight gain.
2. Individual, group and family therapy.
3. Daily involvement with a dietician.
4. Daily monitoring by a psychiatrist with specialty knowledge of anorexia nervosa.
5. Comprehensive medical evaluation with ongoing care as needed.

PARTIAL HOSPITAL TREATMENT:

1. A behavioral approach to developing healthy eating habits with a primary focus on weight gain.
2. At least 5 days/week, 6 hours/day of individual, group and family therapy.
3. Active involvement of the family, if appropriate.
4. Daily involvement with a dietician.
5. Daily contact with a psychiatrist.

INTENSIVE OUTPATIENT TREATMENT:

1. A behavioral approach to developing healthy eating habits with a primary focus on weight gain.
2. At least 3 days/week, 3 hours/day of individual, group and family therapy.
3. Active involvement of the family, if appropriate.
4. Participation in community based support groups.
5. Availability of a dietician every day.
6. Availability of a psychiatrist every day.
OUTPATIENT TREATMENT:

1. A behavioral approach to developing healthy eating habits with a primary focus on weight gain or maintenance.
2. Active involvement of the family.
3. Continuing involvement with a dietician.
4. Participation in community based support groups.
5. Continued monitoring by an internist/pediatrician.
6. Continued monitoring by a psychiatrist, if appropriate.

CONTINUED STAY CRITERIA:

INPATIENT AND PARTIAL HOSPITALIZATION:

1. Gaining weight at the rate of 1-3 lbs./week.
2. Active participation in treatment, including family/significant others.
3. Inability to transition to a lower level of care due to an inability to sustain gains in a less intensive setting.

INTENSIVE OUTPATIENT:

1. Gaining and/or maintaining weight.
2. Active participation in treatment including family/significant others.
3. Inability to transition to a lower level of care due to an inability to sustain gains in a less restrictive setting.

OUTPATIENT:

1. Maintaining weight
2. Active participation with treatment recommendations.
3. Need for additional stabilization before transitioning to community support.

DISCHARGE PLANNING:
1. Since Anorexia Nervosa is a chronic, relapsing condition, discharge planning is directed towards educating the patient and family about signs and symptoms of relapse.

2. At the earliest sign of aberrant behavior the patient should be referred back to their therapist for brief behaviorally oriented refresher therapy.

**DISCHARGE CRITERIA:**

Patients should be discharged when:

- a) They have achieved treatment goals and are transitioned to community care.
- b) They have failed to make significant gains following 2 weeks of inpatient, partial or intensive outpatient treatment, or 4 weeks of outpatient treatment.
- c) They leave AMA.
ACUTE HOSPITAL CARE FOR SUBSTANCE ABUSE

PROGRAM DESCRIPTION:
Acute hospital care is reserved for individuals who are at risk for serious medical complications if their substance abuse is not medically monitored. This would include individuals acutely intoxicated on drugs/alcohol as well as individuals withdrawing from drugs or alcohol. The facility must be a full service medical hospital that has the capability to provide intensive care services.

ADMISSION CRITERIA:
Admission to an acute hospital setting must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to acute care.

GLOBAL INDICATORS:
1. Patient presents at least one valid DSM-IV Axis I diagnosis involving substance dependence. The patient must be dependent on alcohol or sedative/hypnotic drugs. Withdrawal from opiates, stimulants or other drugs of abuse in the absence of a serious acute medical condition, can be accomplished in a less restrictive setting, and

2. Patient has a serious medical condition including withdrawal symptoms that puts them at risk for permanent disability or death if they are withdrawn without medical supervision and/or the patient is at serious risk for death or disability if withdrawal is done without medical supervision, and

3. Alternative outpatient care has been considered, and

4. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:
An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to acute hospital care as evidenced by:
1. History of severe withdrawal symptoms (e.g., delirium, seizures, hallucinations), or
2. Continuous daily use with symptoms of severe withdrawal at the time of evaluation (e.g., CIWA > 20, or
3. An unstable medical condition that would result in significant risk to the patient if they went into severe withdrawal.

**LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:**

As further justification the patient presents with significant limitations in resources to resolve presenting problems as indicated by:

**Limited Personal Resources:** Patient does not have the cognitive or emotional coping skills to facilitate effective outpatient detoxification.

**Limited Social Resources:** Patient does not have the familial or social support to provide the context for outpatient detoxification.

**Exclusions** - Limitations in resources, in and of themselves, are not sufficient justification for admission.

**INTENSITY OF SERVICE ELEMENTS:**

Within this acute care setting, the patient should be receiving the following services as further justification of the admission:

1. Skilled nursing care and level of observation appropriate to risks.
2. Patient is cooperating with caregivers and family involved, as appropriate.
3. Patient receives biomedical intervention (e.g., IV fluids) appropriate to symptomatic presentation.
4. Nutritional status and other relevant general health status assessments.
5. Regular reassessments of mental status.
6. Appropriate pharmacological intervention for withdrawal symptoms as determined by the provider.
7. Discharge planning within 24 hours of admission.
8. Precautions appropriate to suicide potential or elopement risk.

**CONTINUED STAY CRITERIA:**

In order to justify remaining in acute care, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and one or more of the following:

1. .
1. Biomedical symptoms of intoxication or withdrawal remain, and those symptoms place the patient at risk.
2. Biomedical problems would likely interfere with the next stage of treatment.
3. Coexisting psychiatric disorder would significantly interfere with effective transfer to lower level of care.
4. Cognitive and perceptual impairment remains at a level that would produce risk if transferred or discharged.
5. Additional preparation for discharge or transfer will reduce probability of relapse or re-hospitalization.

**DISCHARGE CRITERIA:**

Patient is ready for discharge when one or more of the following criteria are satisfied:

a) Withdrawal symptoms are sufficiently stable that they can be managed as an outpatient.
   b) Individual signs out AMA.
CHILD/ADOLESCENT PARTIAL HOSPITALIZATION PROGRAM

PROGRAM DEFINITION:

This level of care is intended to be an alternative to acute psychiatric inpatient treatment. The level of acuity of patients’ symptoms, intensity of services and length of stay guidelines should all be similar to those of acute psychiatric inpatient treatment. Partial hospitalization should be the initial level of care authorized, and is not intended as a step-down from acute psychiatric inpatient treatment or as an alternative to an Intensive Outpatient Program.

To qualify as a partial hospitalization program, the patient must receive at least eight hours/day of individual and group therapy. The patient must participate in a structured program at least three days/week.

ADMISSION CRITERIA:

Admission to a partial hospitalization program must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to partial hospitalization.

GLOBAL INDICATORS:

1. Patient presents at least one (1) valid DSM-IV Axis I diagnosis exclusive of substance abuse or substance dependence, failure to admit to a partial hospitalization program is likely to result in immediate deterioration requiring inpatient care, and

2. Patient’s condition must be directly attributable to the designated mental disorder and not to patterns of disruptive behavior, or be a part of a pervasive pattern of antisocial conduct, and

3. Patient’s behavior and symptoms are amenable to acute treatment, and

4. Alternative levels and locations of care, such as outpatient care, have been attempted or seriously considered and relapse has occurred within six months of the patient’s active participation in such a program, and

5. Specialized intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.
SEVERITY OF ILLNESS:

An objective, professional evaluation of the patient’s current condition indicates an acute level of severity appropriate to partial hospitalization as evidenced by the following:

**Impairment in Safety:** Patient may be experiencing suicidal/homicidal ideation with a plan and expressed intent. Patient must be able to contract for safety and have a social support system in place when outside of the partial hospital setting. Clinical evidence indicates that a less intensive outpatient setting is not appropriate.

**Impairment in Self-Care:** Patient may be experiencing noticeable impairment in ADLs (i.e., disheveled clothing, unkempt appearance, and poor personal hygiene). Patient may be experiencing significant impairment in their eating and/or sleeping patterns. Patient has a system of social support able to provide for whatever transportation needs are required by the program.

**Impairment in Reality Construction:** The patient is sufficiently intact to benefit from individual and group therapy.

**Impairment in Social Functioning:** This level of care is considered appropriate for patients who are unable to function in unmonitored social/occupational settings. Patient’s acute symptoms disable them from fulfilling occupational roles/responsibilities. Patient may be exhibiting/verbalizing a noticeable decrease in personal interactions. Patient can benefit from continuing involvement with family/social support system.

**Complicating Conditions:** This level of care is appropriate for patients with a demonstrated need for intensive pharmacological intervention. Biomedical complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere with partial hospital care and complications from pharmacological intervention are considered manageable.

**Exclusion** – In the child/adolescent population, partial hospitalization should be delineated from non-acute residential day programs designed for social rehabilitation of patients with pervasive developmental disorders.

**Exclusion** – Unless medically necessary, court-ordered treatment is considered an exclusion.
LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

Patient presents with limitations in resources to resolve presenting problems as indicated by:

**Limited Personal Resources:** Patient has adequate cognitive and emotional coping skills to actively participate in care. Patient is capable of controlling their behavior and/or has the ability to seek professional assistance or other support when outside of the program.

**Limited Social Resources:** Patient has adequate social support system, including a suitable environment outside of the program to provide context for successful partial hospital treatment. The patient’s family must be willing and available to assist the patient outside of the partial hospital setting, and within the partial hospital setting when clinically indicated.

**Exclusion** -
1. Limitations in resources, in and of themselves, are not sufficient justification for admission.
2. In the child/adolescent population, the need for an alternative academic setting in and of itself is not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

Within the partial hospitalization program, the patient should be receiving the following services as further justification of the admission:

1. A comprehensive psychiatric evaluation must be conducted and documented on the day of admission. This evaluation must include an initial treatment plan, tentative discharge plan, and a comprehensive family assessment (family assessment must be completed within 48 hours of admission).
2. The provision of educational services to meet patients’ individualized academic needs.
3. An individualized treatment plan with specific goals and intervention plans.
4. A structured activities schedule with both focused individual and group therapy.
5. A plan exists for management of crisis episodes, when they occur.
6. Linkages with appropriate support groups (e.g., AA or Overeaters Anonymous).
7. A psychiatrist must be available every day of treatment providing daily supervision of care and ongoing medication monitoring and adjustment.
8. Family involvement within the partial hospital setting, including family therapy, should occur twice weekly, unless frequent family involvement would result in clinical exacerbation of the patient’s psychiatric illness.
CONTINUED STAY CRITERIA:

In order to justify remaining in a partial hospitalization program, the patient must continue to manifest symptoms related to the principal DSM-IV diagnosis and the following:

1. Admission criteria must be met.
2. Clinical documentation reflects the patient’s active progress toward treatment goals.
3. Clinical documentation supports justification that a less restrictive level of care would result in exacerbation of the patient’s psychiatric illness.
4. Patient is cooperating with caregivers and actively involved in care.
5. Family involvement is appropriate to the goal of sustaining the progress that is being made.
6. Patient is actively participating in aftercare planning.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:

(a) Completes the treatment plan.
(b) Impairment in functioning can be managed with periodic outpatient treatment.
(c) Patient leaves AMA.
(d) Patient refuses treatment and/or the problems that prompted admission are found not to be amenable to acute treatment.
ADULT AND GERIATRIC PARTIAL HOSPITALIZATION PROGRAM

PROGRAM DEFINITION:

This level of care is intended to be an alternative to acute psychiatric inpatient treatment. The level of acuity of the patient’s symptoms, intensity of services and length of stay guidelines should all be similar to those of acute psychiatric inpatient treatment. Partial hospitalization should be the initial level of care authorized, and is not intended as a step-down from acute psychiatric inpatient treatment or as an alternative to an Intensive Outpatient Program.

To qualify as a partial hospitalization program, the patient must receive at least eight hours/day of individual and group therapy. The patient must participate in a structured program at least three days/week.

ADMISSION CRITERIA:

Admission to a partial hospitalization program must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to partial hospitalization.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis exclusive of substance abuse or substance dependence, failure to admit to a partial hospitalization program is likely to result in immediate deterioration requiring inpatient care, and

2. Patient’s condition must be directly attributable to the designated mental disorder and not to Antisocial Personality Disorder, or be a part of a pervasive pattern of antisocial conduct, and

3. Patient’s symptoms are amenable to acute treatment, and

4. Alternative levels and locations of care, such as outpatient care, have been attempted or seriously considered and relapse has occurred within six (6) months of the patient’s active participation in such a program, and

5. Specialized intervention is considered likely to be effective and is essential to contain risks presented and to provide for improvement.
SEVERITY OF ILLNESS:

Patients must be able to benefit from cognitive therapies as evidenced by the absence of significant cognitive impairment (i.e., Alzheimer’s Disease or Dementia).

An objective, professional evaluation of the patient’s current condition indicates an acute level of severity appropriate to partial hospitalization as evidenced by the following:

Impairment in Safety: Patient may be experiencing suicidal/homicidal ideation with a plan and expressed intent. Patient must be able to contract for safety and have a social support system in place when outside of the partial hospital setting. Clinical evidence indicates that a less intensive outpatient setting is not appropriate.

Impairment in Self-Care: Patient may be experiencing noticeable impairment in ADLs (i.e., disheveled clothing, unkempt appearance, and poor personal hygiene). Patient may be experiencing significant impairment in their eating and/or sleeping patterns. Patient is able to provide for whatever transportation needs required by the program, or has a system of social support to meet transportation needs.

Impairment in Reality Construction: The patient is sufficiently intact to benefit from individual and group therapy.

Impairment in Social Functioning: This level of care is considered appropriate for patients who are unable to function in unmonitored social/occupational settings. Patient’s acute symptoms disable them from fulfilling occupational roles/responsibilities. Patient may be exhibiting/verbalizing a noticeable decrease in personal interactions. Patient can benefit from continuing involvement with family/social support system.

Complicating Conditions: This level of care is appropriate for patients with a demonstrated need for intensive pharmacological intervention. Biomedical complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere with partial hospital care and complications from pharmacological intervention are considered manageable.

Exclusion — In the adult/geriatric population, medical conditions in and of themselves, are not sufficient justification for admission.

Exclusion — In the adult/geriatric population, partial hospitalization should be delineated from non-acute residential day programs designed for social rehabilitation of patients with severe and persistent mental illness.

Exclusion — Unless medically necessary, court-ordered treatment is considered an exclusion.
LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

Patient presents with limitations in resources to resolve presenting problems as indicated by:

**Limited Personal Resources** – Patient has adequate cognitive and emotional coping skills to actively participate in care. Patient is capable of controlling their behavior and/or has the ability to seek professional assistance or other support when outside of the program.

**Limited Social Resources** – Patient has adequate social support system, including a suitable environment outside of the program to provide context for successful partial hospital treatment.

**Exclusion** – Limitations in resources, in and of themselves, are not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

Within the partial hospitalization program, the following program elements must be provided to satisfy medical necessity criteria:

1. A comprehensive psychiatric evaluation must be conducted and documented on the day of admission. This evaluation must include an initial treatment plan and tentative discharge plan.
2. Structured daily program, including nursing and medical supervision.
3. An individualized treatment plan with specific goals and intervention plans.
4. A structured activities schedule with both focused individual and group therapy.
5. Plan exists for management of crisis episodes, were they to occur.
6. Linkages with appropriate support groups (e.g., AA or Overeaters Anonymous).
7. A psychiatrist must be available every day of treatment providing daily supervision of care and ongoing medication monitoring and adjustment.

CONTINUED STAY CRITERIA:

In order to justify remaining in a partial hospitalization program, the patient must continue to manifest symptoms related to the principal DSM-IV diagnosis and the following:

1. Admission criteria must be met.
2. Clinical documentation supports the patient’s active progress toward treatment goals.
3. Clinical documentation shows that a less restrictive level of care would result in exacerbation of the patient’s psychiatric illness.

4. Patient is cooperating with caregivers and actively involved in care.

5. Family involvement is appropriate to the goal of sustaining the progress that is being made.

6. Patient is actively participating in aftercare planning.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when they satisfy any of the following criteria:

a) Completes the treatment plan.

b) Impairment in functioning can be managed with periodic outpatient treatment.

c) Patient leaves AMA.

d) Patient refuses treatment and/or the problems that prompted admission are found to be refractory or chronic.
PARTIAL HOSPITALIZATION PROGRAM – SUBSTANCE ABUSE

PROGRAM DEFINITION:

This level of care is intended to be an alternative to acute substance abuse inpatient treatment or residential treatment care. The level of acuity of patients’ symptoms, intensity of services and length of stay guidelines should all be similar to those of acute substance abuse inpatient treatment.

To qualify as a partial hospitalization program, the patient must receive at least eight hours/day of individual and group therapy. The patient must participate in a structured program at least three days/week.

ADMISSION CRITERIA:

Admission to a partial hospitalization program must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to partial hospitalization.

GLOBAL INDICATORS:

1. Patient presents at least one (1) valid DSM-IV Axis I diagnosis of substance abuse or substance dependence, failure to admit to a partial hospitalization program is likely to result in immediate deterioration requiring acute inpatient care, and

2. The patient is medically stable and not in acute withdrawal that would require 24-hour medical monitoring, and

3. Patient’s symptoms are amenable to day treatment, require a structured program with medical supervision and/or treatment for part of each day, and

4. The patients substance dependence and abuse is excessive, and the patient has attempted to reduce or control it, but has been unable to do so, and

5. Alternative levels and locations of care, such as intensive or traditional outpatient care, have been attempted or seriously considered and relapse has occurred within six (6) months of the patient’s active participation in such a program, and

6. Specialized intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.
SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to partial hospitalization care as evidenced by the following:

**Impairment in Safety:** Patient presents risk of danger to themselves through suicide or a danger to others through assaultive or homicidal behavior and periods when harm to self or others risk is considered high.

**Impairment in Self-Care:** Patient presents significant impairment in capacity for self care without being monitored in a highly structured environment due to substance dependency and as such, presents potential harm to self.

**Impairment in Reality Construction:** Presents significantly diminished ability to obtain essential information from the environment, to problem solve effectively and to respond to treatment efforts at lower levels of care (i.e., outpatient).

**Impairment in Social Functioning:** Pattern of dependence has seriously impaired the patient’s social, family and occupational functioning, there is a reasonable expectation that significant functioning can be restored with partial hospitalization care and that such functioning is unlikely to be restored through treatment at a lower level of care.

**Complicating Conditions:** Physiological complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.

**Exclusion** – In the adult/geriatric population, medical conditions in and of themselves, are not sufficient justification for admission.

**Exclusion** – Unless medically necessary, court-ordered treatment is considered an exclusion.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

Patient presents with limitations in resources to resolve presenting problems as indicated by:

**Limited Personal Resources** – Patient has adequate cognitive and emotional coping skills to actively participate in care. Patient is capable of controlling their behavior and/or has the ability to seek professional assistance or other support when outside of the program.
Limited Social Resources – Patient has adequate social support system, including a suitable environment outside of the program to provide context for successful partial hospital treatment.

Exclusion – Limitations in resources, in and of themselves, are not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

Within the partial hospitalization program, the following program elements must be provided to satisfy medical necessity criteria:

1. A comprehensive psychiatric evaluation must be conducted and documented on the day of admission. This evaluation must include an initial treatment plan and tentative discharge plan.

2. Structured daily program, including nursing and medical supervision.

3. A psychiatrist or addictionologist must be available as needed every day of treatment providing supervision of care and ongoing medication monitoring and adjustment.

4. An individualized treatment plan with specific goals and intervention plans. A specific treatment goal is the reduction in severity of symptoms and improvement in level of functioning sufficient to return patient to a less intensive level of care.

5. The treatment plan includes a linkage and/or coordination with the available structured and supportive community based resources.

6. A structured activities schedule with both focused individual and group therapy.

7. Plan exists for management of crisis episodes, were they to occur.

CONTINUED STAY CRITERIA:

In order to justify remaining in a partial hospitalization program, the patient must continue to manifest symptoms related to the principal DSM-IV diagnosis and the following:

1. Admission criteria must be met.

2. Clinical documentation supports the patient’s active progress toward treatment goals.

3. Clinical documentation shows that a less restrictive level of care would result in exacerbation of the patient’s substance dependence.

4. Patient is cooperating with caregivers and actively participating in care.

5. The current or revised treatment plan can be reasonable expected to bring about significant improvement in the problems that caused the admission, and the patient’s
progress is documented at least three times per week. The treatment plan includes a plan for discharge.

6. Patient is actively participating in aftercare planning.

7. Family involvement is appropriate to the goal of sustaining the progress that is being made.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when they satisfy any of the following criteria:

a) Patient no longer meets criteria for continued stay.

b) Patient can sustain progress and resolve remaining treatment goals in a less restrictive environment (i.e., IOP, traditional outpatient services).

c) Patient has deteriorated and needs to be admitted to a higher level of care.

d) Patient has not engaged in treatment and further progress is unlikely.

e) Patient leaves AMA.
STRUCTURED INTENSIVE OUTPATIENT PROGRAM FOR PSYCHIATRIC DISORDERS

PROGRAM DEFINITION:

To qualify as an intensive outpatient program the patient must receive at least 2½ hours per day of individual and/or group therapy. The patient must participate in treatment at least three days per week.

ADMISSION CRITERIA:

1. Patient has the cognitive ability to understand and process in both individual and group therapy modalities.

2. Patient has the emotional stability to actively participate in both individual and group therapies.

3. Patient has the capacity to develop and implement skills and strategies that will enable them to function more independently.

4. Patient has some limitations in their social support systems.

Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for admission.

GLOBAL INDICATORS:

1. Patient presents at least one DSM-IV Axis I diagnosis and, failure to admit to an intensive outpatient program is likely to result in significant psychological impairment, which would require a more structure level of care, and

2. Patient's condition must be directly attributable to the designated mental disorder and not to a personality disorder or be a part of a pervasive pattern of antisocial conduct, and

3. Alternative levels and locations of care, such as outpatient care have been attempted or seriously considered and relapse has occurred within 6 months of the patient's active participation in such a program.
SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to IOP as evidenced by the following:

**Impairment in Safety:** The patient may be experiencing suicidal or homicidal ideation without expressed intentions or a plan with no prior history of attempts.

**Impairment in Self Care:** The patient may be experiencing noticeable impairment in ADLs (i.e., disheveled clothing, unkempt appearance, and poor personal hygiene). Patient may be experiencing significant disturbances in their eating and/or sleeping patterns.

**Impairment in Reality Orientation:** The patient may experience disturbances in their thought processes but possess the cognitive ability to distinguish between them and reality.

**Impairment in Social Functioning:** The patient may be exhibiting/verbalizing a noticeable decrease in personal interactions. Patient is displaying some signs of anhedonia. Patient is experiencing difficulty fulfilling roles and responsibilities (i.e., job, parenting,). Social and occupational functioning is at a level that will permit success of an IOP program. Patient will benefit from continuing involvement with family/significant others and at work during treatment.

**Complicating Conditions:** Physiological complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.

INTENSITY OF SERVICE ELEMENTS:

Within IOP, the patient should be receiving the following services as further justification of the admission:

1. A comprehensive psychiatric evaluation must be conducted and documented on the day of admission. This evaluation must include an initial treatment plan and tentative discharge plan.

2. An individualized treatment plan with specific goals and intervention plans.

3. A structured activity schedule with focused individual, family, and group therapy.

4. Plan exists for management of crisis episodes if they to occur.

5. Linkages with appropriate support groups if applicable (e.g., AA or Overeaters Anonymous).

6. An independently licensed mental health professional must be available every day of treatment providing daily supervision of care.
7. A medical director will oversee the program and be involved in the development of individual treatment plans.

**CONTINUED STAY CRITERIA:**

In order to justify remaining in an IOP program, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Adequate progress is taking place, goals are being approximated and longer stay is essential to achieve goals.
2. Patient is being stabilized and maintained in a way that avoids hospitalization.
3. Patient is cooperating with caregivers and actively involved in care as evidenced by documentation of participation and attendance.
4. Family involvement is appropriate to the goal of sustaining the progress that is being made.
5. Aftercare planning is taking place and the patient is involved in those plans.
6. Patient has consistent attendance.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when they satisfy any of the following criteria:

a) Completes the treatment plan.

b) Impairment in functioning can be managed with periodic outpatient treatment.

c) Patient leaves AMA.

d) Patient refuses treatment, and/or the problems that prompted admission are found to be refractory or chronic.

e) Patient does not have consistent pattern of compliance with attendance prescribed in treatment plan.
STRUCTURED INTENSIVE OUTPATIENT PROGRAM FOR SUBSTANCE ABUSE AND DEPENDENCY DISORDERS

PROGRAM DEFINITION:

To qualify as an intensive outpatient program the patient must receive at least 2½ hours/day of individual and/or group therapy. The patient must participate in treatment at least three days/week.

ADMISSION CRITERIA:

1. Patient has failed to maintain sobriety when treated in a less restrictive level of care.

2. Patient has been discharged from a more restrictive level of care and requires significant structure and monitoring in order to maintain sobriety.

3. Patient has the cognitive ability to understand and process in both individual and group therapy modalities.

4. Patient has the emotional stability to actively participate in both individual and group therapies.

5. Patient has the capacity to develop and implement skills and strategies that will enable them to function more independently.

6. Patient has some limitations in their social support systems.

Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for admission.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis related to substance abuse or dependency, and failure to admit to an intensive outpatient program is likely to result in immediate psychological deterioration and progression in substance abuse which would require inpatient care, and

2. Patient's condition must be directly attributable to the designated Axis I diagnosis and not to a Personality Disorder or be a part of a pervasive pattern of antisocial conduct, and
3. Alternative levels and locations of care, such as outpatient care have been attempted or seriously considered, and relapse has occurred within 6 months of the patient's active participation in such a program.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of substance abuse/dependence appropriate to IOP as evidenced by the following:

Impairment in Safety: Patient may be experiencing significant cravings for substance(s) of choice but vital signs are within normal limits. May be experiencing suicidal or homicidal ideation without expressed intentionality or a plan with no prior history of attempts.

Impairment in Self-Care: Patient may be experiencing noticeable impairment in ADLs, (i.e., disheveled clothing, unkempt appearance and poor personal hygiene). May be experiencing significant disturbances in their eating and/or sleeping patterns.

Impairment in Social Functioning: Patient may be exhibiting/verbalizing a noticeable decrease in personal interactions. Patient is displaying some signs of anhedonia. Patient is experiencing difficulty fulfilling roles and responsibilities (i.e., job, parenting). Social and occupational functioning is at a level that will permit success of an IOP program. Patient will benefit from continuing involvement with family/significant others and at work during treatment.

Complicating Conditions: Physiological complications are minimal, coexisting psychological problems (e.g., depression) will not significantly interfere. Care and complications from pharmacological intervention are considered manageable.

INTENSITY OF SERVICE ELEMENTS:

Within IOP, the patient should be receiving the following services as further justification of the admission:

1. A comprehensive psychiatric evaluation including an extensive substance abuse history must be conducted and documented on the day of admission. This evaluation must include an initial treatment plan and tentative discharge plan.

2. An individualized treatment plan with specific goals and intervention plans.

3. A structured activity schedule with focused individual, family, and group therapy

4. A plan exists for management of crisis episodes if they occur.

5. At a minimum documentation of weekly attendance at two to three support groups (e.g., AA, NA, Alanon, Alateen, etc.).
6. Random weekly screens to verify sobriety.
7. Obtaining and having regular documented contact with a sponsor.
8. An independently licensed mental health professional with substance abuse certification must be available every day of treatment providing daily supervision of care.
9. A medical director will oversee the programming and be involved in the development of individual treatment plans.

CONTINUED STAY CRITERIA:

In order to justify remaining in an IOP program, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis of substance abuse and/or dependence and the following:

1. Adequate progress is taking place, goals are being approximated, and longer stay is essential to achieve goals.
2. Patient is being stabilized and maintained in a way that avoids hospitalization.
3. Patient is cooperating with caregivers and actively involved in care.
4. Family involvement is appropriate to the goal of sustaining the progress that is being made.
5. Sobriety as evidenced by random weekly drug screens
6. Documentation of attendance at all weekly support group meetings required by treatment plan.
7. Ongoing documentation regarding the involvement of a sponsor as required by the treatment plan.
8. Aftercare planning is taking place, and the patient is involved in those plans.
9. Active participation in relapse prevention planning.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:

a) Completes the treatment plan.
b) Impairment in functioning can be managed with periodic outpatient treatment, or
c) Patient leaves AMA.
d) Patient refuses treatment, and/or the problems that prompted admission are found to be refractory or chronic.
e) Patient fails weekly drug screen.
f) Patient does not have consistent documented attendance at treatment program and/or support group meetings.
g) Patient does not have consistent documented communication with their sponsor.
OUTPATIENT SERVICES

ADMISSION CRITERIA:

Admission to outpatient services must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and an Intensity of Services appropriate to outpatient care.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I or Axis II diagnosis, other than Learning Disorders, Mental Retardation, Communication Disorders, Pervasive Developmental Disorders or chronic conditions associated with Delirium, Dementia, Amnesia and other Cognitive Disorders, Nicotine Related Disorders, V codes, and

2. The patient has one or more specified behavioral disturbances that is/are amendable to short term intervention and/or require(s) ongoing treatment to prevent deterioration to the point of hospitalization and patient's condition must be directly attributable to the designated mental disorder and not to Antisocial Personality or be a part of a pervasive pattern of antisocial conduct, and

3. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to outpatient services as evidenced by one or more of the following:

Impairment in Safety: Patient presents levels of risk to self or others that can be adequately managed in an outpatient setting.

Impairment in Self Care: Patient has adequate self care skills to maintain themselves without substantial risk while being seen over time in an outpatient setting.

Impairment in Reality Construction: Patient has adequate grasp of reality and capacity for judgment to contain risks while being seen on an outpatient basis.

Impairment in Social Functioning: Impairment in social, family, occupational or educational functioning is not of sufficient magnitude to preclude obtaining benefit from outpatient therapy.
Complicating Conditions: Complications are considered minimal.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

As further justification, the patient presents with significant limitations in resources to resolve presenting problems as indicated by:

Limited Personal Resources: Patient has adequate coping skills to contribute to recovery through active participation and to carry out assigned tasks between sessions.

Limited Social Resources: Patient has adequate family and/or social support to provide context for periodic outpatient intervention.

Exclusions - Limitations in resources, in and of themselves, are not sufficient justification for services.

INTENSITY OF SERVICE ELEMENTS:

Within outpatient care the patient should be receiving the following services as further justification of the admission:

1. An individualized treatment plan with specific goals and attendant plans for intervention.
2. Symptoms described correspond to the diagnosis and meet criteria as specified in DSM-IV.
3. Plans include interventions appropriate to crises were they to occur (e.g., 24 hour call capacity).
4. Frequency and duration of contact appropriate to the plan of care (e.g., weekly or monthly).
5. Patient strengths recognized and mobilized in service of obtaining the goals of care.

CONTINUED STAY CRITERIA:

In order to justify remaining in outpatient care the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and one or more of the following:

1. Progress is being made in obtaining the goals in the plan of care.
2. Additional sessions are required to achieve final goals and interrupt current episode of care.
3. Patient is showing up for appointments and cooperating with homework assignments and other aspects of care.
4. Frequency of sessions and duration of each session is appropriate to current stage in the sequence of care.

5. Changes in environmental stress have led to justifiable modification in the plan of care.

**DISCHARGE CRITERIA:**

Termination or interruption of outpatient care is appropriate under the following conditions:

- a) Goals of the plan of care have been attained.
- b) Patient is capable of functioning in community without professional help.
- c) Patient has proven uncooperative and further care is unlikely to be productive.
- d) Lack of progress has been documented and further care is not deemed appropriate.
- e) Patient has dropped out of therapy.
- f) Patient terminated against clinical advice.
OUTPATIENT DETOXIFICATION

PROGRAM DESCRIPTION: Outpatient detoxification programs provide medical supervision for individuals who are committed to becoming abstinent and who are experiencing significant withdrawal symptoms. The program must have the capacity to treat individuals who are physically dependent on alcohol, sedative/hypnotics or opiates. Treatment of individuals who are abusing other drugs (e.g. hallucinogens, stimulants) can be provided in the event they need medical supervision. The program must have the capability to perform psychiatric and medical evaluations as well as laboratory testing. It must have the capacity to monitor patients for at least 4 hours. Medical supervision must be available 7 days/week.

ADMISSION CRITERIA:

Patient has been actively abusing drugs or alcohol, and they are at risk for injury, deterioration or disability if they don’t receive medically care for withdrawal symptoms.

GLOBAL INDICATORS:

1. Patient presents at least one valid DSM-IV Axis I diagnosis of substance dependence, and

2. Patient's condition must be directly attributable to a substance-related disorder and not to Antisocial Personality or be a part of a pervasive pattern of antisocial conduct.

3. Specialized intervention is considered likely to be effective and to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to an outpatient detoxification facility as evidenced by one or more of the following:

Impairment in Safety: Patient presents risks of deterioration, disability or death if they are not medically supervised during withdrawal.

Impairment in Self Care: Substance dependency is such that capacity for essential self-care has been temporarily diminished in a way that imposes immediate risk to the patient and the attendant risks can be reduced by medically supervised detoxification.
**Impairment in Reality Construction:** Patient is sufficiently intact that they can, with the assistance of others, participate in outpatient treatment.

**Impairment in Social Functioning:** Patient’s social and/or family functioning must be sufficiently intact to permit outpatient detoxification.

**Complicating Conditions:** Patient has underlying medical condition(s) that would be exacerbated if they do not receive medically supervised detoxification.

**LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:**

Patient presents with significant limitations in resources to resolve presenting problems as indicated by:

- **Limited Personal Resources:** None.
- **Limited Social Resources:** Patient must have sufficient resources to monitor their withdrawal and obtain emergency medical care, if necessary, on an outpatient basis.

**Exclusion** - Limitations in personal or social resources, in the absence of a need for medically managed detoxification, are not sufficient justification for admission.

**INTENSITY OF SERVICE ELEMENTS:**

Within this detoxification setting the patient should be receiving the following services as further justification of the admission:

1. Comprehensive medical/psychiatric/substance abuse history and physical examination.
2. Laboratory testing as appropriate
3. Individualized plan of care that recognizes unique characteristics, problems and motivations. The plan must include anticipated length of stay and frequency of follow-up visits.
4. Medical interventions appropriate to detoxification risks and/or physical complications that attend the patient's dependency.
5. Discharge planning within 24 hours of admission.
6. Co-morbid conditions identified and treated when appropriate (e.g., significant depression).

**CONTINUED STAY CRITERIA:**
In order to justify remaining in a detoxification program the patient must:

1. Remain abstinent from alcohol and drugs of abuse.
2. Be receiving medications to manage the symptoms of withdrawal.
3. Patient is cooperating fully with the treatment team and is giving evidence of motivation to address dependency issues.
4. Patient continues to be at risk for deterioration, disability or death if not medically monitored.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when they satisfy any of the following criteria:

a) They complete the treatment plan.

b) The risk of deterioration or disability can be managed in a less restrictive setting.

c) The patient leaves AMA.
Psychological and Neuropsychological Testing

**Introduction**

The goal of behavioral health assessment is to determine the nature, type, and extent of an individual’s mental or emotional condition and, if appropriate, develop a working diagnosis and initial treatment plan. Psychological testing can be an effective component of a behavioral health assessment, but it is not a substitute for a thorough clinical interview conducted by a qualified mental-health professional. Proposed psychological testing should address specific diagnostic or treatment questions. [1-4] Formal psychological testing is not clinically indicated for routine screening or first-line assessment of behavioral health disorders [1, 5]

Psychological testing is designed to provide information about a person’s personality, emotional and interpersonal functioning and clinical symptoms. Neuropsychological testing measures higher cortical functioning and a person’s cognitive strengths and weaknesses.

Requests for authorization of psychological testing must meet all of the following criteria:

1) The referral for psychological testing must be made by a physician, licensed psychologist, or other qualified, licensed mental health professional.

2) The request must be preceded by a comprehensive initial evaluation by a licensed mental health professional and must address clearly-defined clinical questions. It is preferable that this initial evaluation is completed by the same person who would be performing the psychological testing.

3) The purpose of the testing is:
   - a) To clarify diagnosis once a thorough evaluation conducted by a licensed mental health professional has failed to provide viable working diagnostic information (for a covered DSM IV-TR diagnosis)
   - b) There is uncertainty regarding the treatment plan or course, or the individual has not responded to alternate levels of care (including medication, if appropriate), and testing will have a direct impact on the treatment plan.
   - c) Testing is likely to yield information that is otherwise unavailable from alternate sources which could verify the presence of emotional or cognitive deficits adversely impacting the individual’s ability to participate in, or benefit from, treatment.

**Inclusion criteria**  (Either 1 or 2 plus 3 and 4 are necessary)

1. Testing is necessary to establish a differential diagnosis (for covered DSM-IV diagnoses) after at least three (3) of the following have been unsuccessful, and diagnostic clarification is crucial to establishing a treatment plan.
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a. Clinical Interview
b. Mental Status Exam (MSE)
c. Brief Rating Scale (e.g., BDI)
d. Comprehensive psychosocial behavioral history
e. Behavioral Observation (separate from clinical interview

- If at least three of these have not been completed, the request can be pended and additional visits (90806 etc.) can be authorized to allow for completion of missing elements.

2. Despite compliance with the plan of care established for the working diagnosis, the patient has not responded to the established treatment plan, at least two attempts to adjust the treatment plan have not resulted in a favorable response, and testing will clarify the necessary adjustment to the treatment plan.

3. Testing cannot be obtained from school, care facility or employer with which the designated member is associated.

4. The results of previous psychological testing are not available, or testing was conducted more than eighteen (18) months ago.

Qualifying Service Providers Testing should only be performed by practitioners who are appropriately trained in administration of tests, including:

1. Independently State Licensed Doctoral Level Psychologist (CPT codes 96101, 96118 must be authorized to this level of provider)
2. Qualified Psychometrist or Psychometrician (CPT codes 96102, 96119 for these specialists or for primary Psychologist)
3. Psychological testing may also be authorized by MHNet (as an exception to the general requirement for test administration by a doctoral level independently licensed psychologist), for independently state licensed psychologists or other mental health professionals with a Master’s degree, or certified neuro-behavioral psychiatrists who meet the following criteria:

- The provider’s state licensure specifically allows for provision of psychological testing service;
- The provider has professional training and expertise in the types of tests/assessment being requested; and
- The provider can conduct test administration, scoring and interpretation in accordance with currently prevailing national professional and ethical standards regarding testing service.

Conditions and Provisions for Psychological Testing

1. Requested tests are relevant and valid for evaluating the clinical concerns under consideration.
2. All tests performed must possess sound psychometric properties, including empirically substantiated reliability, validity, standardized administration and clinically relevant normative data based on age, education and, when relevant, ethnicity and gender.
3. Following completion of psychological testing, it is expected that the provider will compose a final report which, at minimum, summarizes clinical impressions and recommendations that will be forwarded to the referring provider.

Exclusion Criteria

1. Testing requested for purposes that are specifically excluded in the health plan COC
2. Testing mandated by a court of law, employer or educational institution as condition of probation, parole, custody, continued employment or return from school suspension
3. Testing primarily for educational or vocational purposes
4. Testing to establish baseline for cognitive rehabilitation
5. Testing utilizing instruments that have no standardized norms or documented validity
6. Testing where time requests exceed established time parameters
7. Testing for purposes of custody determination independent of diagnosis or plan of care established via admission criteria listed above
8. Testing that is for routine assessment or a routine requirement for entrance into a treatment program or for an update of the member’s level of functioning
9. Testing primarily for the purpose for the titration of medication, in the absence of the Medically necessary inclusion criteria
10. More than two tests are requested that measure the same cognitive, emotional or behavioral domain

Testing for ADHD

A diagnosis of ADHD can routinely be determined by means of a thorough diagnostic interview that may include the use of behavior rating scales and symptom checklists. Testing may be a useful service when a conclusive diagnosis, evaluation of specific deficits related to or co-existing with ADHD and/or the continued validity of ADHD as an existing diagnosis is in question and/or is needed to guide continued medication treatment and cannot be determined by standard interview and behavior rating scale assessment alone. Tests directly related to the measurement of associated academic-educational problems or achievement level may be excluded from coverage, depending on coverage exclusions listed in the member’s Certificate of Coverage or relevant summary plan document.

CPT Codes for Psychological and Neuropsychological Testing
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*Psychological testing*: CPT 96101, 96102, 96103
*Neuropsychological testing*: CPT 96116, 96118, 96119, 96120

**Unauthorized Tests**

Projective techniques (i.e., Rorschach, projective storytelling (TAT) incomplete sentence blanks, and drawings such as the House-Tree-Person) are not considered medically necessary for diagnostic and treatment-planning purposes. Although some clinicians have asserted the usefulness of these measures, the TAT and most sentence completion and drawing tests are not standardized, and the clinical value of the information they do yield (such as personality traits) has not been empirically established. See references [6, 7]

**Peer Review**

In most cases, the MHNet reviewer is a licensed psychologist (requires doctoral degree in most states). The MHNet reviewer will be at least the same level of licensure as the requesting clinician, have competency in the same or similar specialty area, and hold an active, unrestricted professional license, unless there are state laws that specify the type of professional who can issue an adverse determination. A peer-to-peer review will be offered to the psychologist/provider in the event that it becomes unclear as to whether the services for which authorization is requested meet medical necessity criteria (MNC).

**Reimbursable Time**

Reimbursable time for test administration, scoring and interpretation is based on time reported in scholarly, peer-reviewed publications and/or available from test publishers. The total time authorized includes time for test administration, scoring and interpretation. Attached, for review, is a listing of tests and the time allotments for each, including time for administration, scoring and interpretation. Authorized time should not exceed these allotments unless there is evidence of a case-specific factor(s) necessitating additional time (i.e., a language issue or a disability).

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**Neuropsychological Testing**

**Introduction**
Neuropsychological testing is focused on providing information relevant to the determination of the presence of damage or dysfunction of the brain and associated functional deficits. Neuropsychological testing typically includes tests to measure attention, concentration, learning, memory, problem-solving, language, visual-spatial, motor and executive functioning. It requires specialized postdoctoral training and expertise. Neuropsychological testing frequently involves clinical concerns related to neurological diagnoses rather than behavioral health conditions.

Neuropsychological testing may be medically necessary for the following purposes:

1. Differential diagnosis of a mental disorder due to a neurological condition vs. psychiatric diagnosis when the diagnosis cannot be established through standard psychiatric or neurological examination.
2. Confirming or ruling out conditions where there is known or suspected neurological disease not detectable by standard neurodiagnostic procedures.
3. Clinical conditions involving the likelihood of specific brain based pathology including head injuries, dementia, encephalopathy, multiple sclerosis, exposure to toxins and epilepsy.
4. Adequate psychiatric evaluation or medical examination has been completed.
5. Presence of one or more symptoms of mental disorder due to a neurological medical condition.
6. An adequate mental status exam, patient history and neurological consult have preceded the request for neuropsychological testing and at least one of the following exists:
   a) There are cognitive deficits currently unexplained, significant memory loss or a significant change in either mental status or behavior.
   b) There is already evidence of neurological disease or trauma and neuropsychological testing is indicated to determine their capabilities and facilitate recommendations that may allow for compensation of deficits.
   c) There is a degenerative neurological disease process and testing is needed to establish a baseline or indicate changes in the patient’s capabilities that will affect their treatment plan.
   d) Follow-up testing is typically not authorized until after one (1) year has elapsed, unless it becomes clear from the clinical picture that earlier retesting is essential to the effectiveness of the patient’s treatment plan.

**Reimbursable Time**

See above guidelines for psychological testing. Time authorized for neuropsychological testing shall not exceed nine (9) hours for test administration, scoring and interpretation unless there is evidence of a case-specific factor(s) necessitating additional time (i.e., a language issue or a disability).
References
IN-HOME SERVICES

ADMISSION CRITERIA:

Admission to In-Home services must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and by Intensity of Services appropriate to this level of care.

GLOBAL INDICATORS:

1. Patient presents with at least one valid DSM-IV Axis I diagnosis, other than Conduct Disorder or other excluded diagnosis, and

2. Patient meets criteria for outpatient services but is physically or psychologically unable to attend programming without extraordinary assistance (i.e., ambulance service) and, patient is not in an institutional or residential setting, and patient’s condition must be directly attributable to the designated mental disorder and not to a pervasive pattern of antisocial conduct, and

3. Alternative treatment options have been attempted and were unsuccessful in alleviating symptoms, and

4. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient’s current condition indicates a level of severity appropriate to the services provided through In-Home treatment as evidenced by the following:

Impairment in Safety: Patient presents minimal or manageable risk to self or others. Management of presenting symptoms can be successfully accomplished through outpatient services.

Impairment in Self Care: Patient or legal custodian is able to meet daily self care needs but requires assistance and intervention in order to function successfully in the home setting. Compliance with medications is uncertain; In-Home services may facilitate the monitoring of compliance and prevent unnecessary hospitalizations.

Impairment in Reality Construction: Patient has an adequate grasp of reality and has the capacity to contain risks without more restrictive interventions.
Impairment in Social Functioning: There may be substantial social and environmental factors that contribute to impaired functioning.

Complicating Conditions: Health problems may prevent the patient from participating in traditional, in-office treatment. In-home therapy presents the opportunity for therapy to be provided. There may also be strong suspicion that the home environment is contributing substantially to the mental disorder and without evaluating and intervening in the home setting, treatment success is unlikely.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

As further justification, the patient presents with significant limitations in resources to resolve presenting problems as indicated by:

Limited Personal Resources: Patient has adequate age-appropriate coping skills to contribute to treatment success through active participation ability to complete assigned tasks between sessions. The patient and family may require assistance in identifying available resources. Compliance with treatment, especially as it relates to medications, is questionable.

Limited Social Resources: Patient has adequate family and/or social support to provide the successful context for In-Home interventions. The participation of family members or legal custodian(s) is essential for In-Home services to be successful.

INTENSITY OF SERVICE ELEMENTS:

Within In-Home care, the patient should be receiving the following services as further justification of the admission:

1. An individualized treatment plan with specific goals and attendant plans for intervention.
2. Symptoms described correspond to the diagnosis and meet criteria as specified in DSM-IV.
3. Plans include interventions appropriate to crises were they to occur (e.g., 24 hour call capacity).
4. Frequency and duration of contact appropriate to the plan of care (e.g., weekly or monthly).
5. Patient strengths recognized and mobilized in service of obtaining the goals of care.
6. There are circumstances that justify In-Home as opposed to in-office visits as the most efficient and appropriate method of delivering services (e.g., physical conditions
that make leaving the home difficult).

CONTINUED STAY CRITERIA:

In order to justify receiving In-Home care the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and one or more of the following:

1. Additional sessions are required to achieve final goals. Frequency of sessions is appropriate to the severity of symptoms and is adjusted appropriately as symptoms subside and the patient is able to function in an increasingly functional manner.

2. Patient and family strengths are recognized and mobilized in service of obtaining the goals of care. Progress is being demonstrated and benefit is being derived from treatment interventions, education, and other services.

3. Changes in the home environment have led to justifiable modifications in the plan of care.

4. The circumstances that justified In-Home as opposed to in-office visits continue to be relevant to the continued delivery of services.

DISCHARGE CRITERIA:

Termination or interruption of In-Home services is appropriate under the following conditions:

a) Goals of the plan of care have been attained.

b) Patient/legal custodian have been uncooperative and further care is unlikely to be productive.

c) Lack of progress has been documented and further care is not deemed appropriate.

d) The circumstances leading to In-Home services have subsided, allowing the patient and family to participate in in-office or other forms of treatment as needed.

e) Patient or patient’s legal guardian has terminated treatment.

f) Substantial noncompliance has been documented.

g) The family or legal custodian has been uncooperative in achieving treatment objectives.
TARGETED CASE MANAGEMENT

ADMISSION CRITERIA:

Authorization of Targeted Case Management must be based on the following Global Indicators, Indicators of Severity of Illness and further justified by Limitations of Personal and/or Social Resources and an Intensity of Service appropriate to the objectives of Targeted Case Management.

GLOBAL INDICATORS:

1. Patient presents with at least one valid DSM-IV Axis 1 diagnosis, other than Learning Disorders, Mental Retardation, Communication Disorders, Pervasive Development Disorders, or chronic conditions associated with Delirium, Dementia, Amnesia and other Cognitive Disorders, Nicotine Related Disorders, V codes, and

2. Patient’s condition must be directly attributable to the designated mental disorder and not to Antisocial Personality or be a part of a pervasive pattern of antisocial conduct.

3. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

4. Professional intervention is considered to be likely to be effective and is essential to contain risks presented and provide for improvement.

SEVERITY OF ILLNESS:

An objective professional evaluation of the patient’s current condition indicates a level of severity appropriate to Targeted Case Management services as evidenced by one or more of the following:

Impairment in Safety: Patient presents levels of risk to self and/or others that can be adequately managed in the home environment and outpatient setting.

Impairment in Self Care: Patient can provide for self care or has the age-appropriate assistance in maintaining self care.

Impairment in Reality Construction: Patient has adequate grasp of reality and demonstrates capacity for judgment to contain risks outside of a hospital or other structured setting.

Impairment in Social Functioning: Impairment is not so substantial as to require a
more restricted setting than what is available in the home environment.

**Complicating Factors:** Multiple agencies and service delivery systems are frequently involved in the care of the patient. Impaired family functioning may contribute substantially to the mental illness/substance abuse of the identified patient.

**LIMITATION IN PERSONAL AND/OR SOCIAL RESOURCES:**

As further justification the patient presents with significant limitations in resources to resolve presenting problems as indicated by:

**SPECIFIC CIRCUMSTANCES THAT MAY REQUIRE TARGETED CASE MANAGEMENT:**

The following situations are frequently found to benefit from Targeted Case Management:

1. Pregnant patients whose pregnancy is at risk if their Axis I illness is not controlled.
2. Patients with a history of multiple recent inpatient admissions who are at high risk for readmission.
3. Patients with multiple recent episodes of ambulatory care who are likely to deteriorate and require a higher level of care.
4. Children or adolescents with an active Axis I problem who are victims of abuse or neglect.
5. Recently discharged patients who require intensive community/social support in order to prevent deterioration and readmission.
6. Patients who have recently made a severe, life-threatening suicide attempt.
7. Patients who have been recently hospitalized who have a past history of non-compliance with outpatient care and/or patients whose guardians have been unsupportive of outpatient care.
8. Patients with multiple complicating factors (medical, social, financial) that require ongoing assistance in order to avoid deterioration and higher levels of care.

**Limited Personal Resources:** Patient has adequate age-appropriate coping skills to contribute to treatment success through active participation and the ability to complete assigned tasks between sessions. The family or legal custodian requires help in effectively intervening on the pathological behaviors of the patient. The patient and family may require assistance in identifying available resources. In many instances, the appropriate recipient of Targeted Case Management services is one who is at high risk for repeated hospitalizations and who has multiple agencies involved in care.
Limited Social Resources: Patient has adequate family and/or social support to provide the successful context for Targeted Case Management services. The participation of family members or legal custodian(s) is essential for Targeted Case Management services to be successful.

INTENSITY OF SERVICE ELEMENTS:

When Targeted Case Management is being provided, treatment should include the following services as further justification for continued care:

1. An individualized treatment plan with specific goals and attendant plans for interventions. The treatment plan includes the active participation and involvement of the family/legal custodian and identifies collaborative agencies and their roles in the comprehensive treatment of the patient.

2. Symptoms described correspond to the diagnosis and meet criteria as specified in the DSM-IV.

3. Plans include interventions appropriate to crises as they occur (e.g., 24 hour call capacity).

4. Frequency and duration of contact are appropriate to the plan of care.

5. Multiple agencies are involved in delivering services. Coordination of services will help minimize redundancy as well as ensure a cohesive and efficient treatment planning approach.

CONTINUED STAY CRITERIA:

In order to justify continued Targeted Case Management services, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and one of the following:

1. The patient continues to obtain services from multiple agencies such that the coordination of such care is determined to be essential for the positive outcome of treatment.

2. The patient remains high risk for multiple hospitalizations or other forms of intensive treatment. Targeted Case Management has reduced the risks associated with high utilization of treatment provided in restricted environments.

3. The patient and family is compliant with treatment and progress is being made in achieving treatment plan goals.
DISCHARGE CRITERIA:

Termination or interruption of Targeted Case Management is appropriate under the following conditions:

a) The patient’s condition has improved to the point that treatment can proceed within the scope of traditional outpatient services.

b) The patient and/or family are uncooperative with treatment and further progress seems unlikely.

c) Progress as documented in the record does not justify continuation at this level of care.

d) Another agency assumes responsibility for the care of the patient.

e) Patient discharges AMA.
ECT CRITERIA

CREDENTIALING PROVIDERS:

Psychiatrists must have specialized training to conduct ECT. MHNet will approve providers to perform ECT if they are currently credentialed to perform ECT by a JCAHO accredited hospital or they provide evidence of training in the procedure and they are currently providing at least 30 treatments/year.

FACILITY REQUIREMENTS:

Anesthesiologists with experience in ECT and/or Certified Registered Nurse Anesthetists trained in ECT who are supervised according to the regulations of the state where they are practicing must attend to all ECT procedures.

The facility must have equipment that can continuously monitor vital signs and oxygen tension. The facility must have continuous oxygen available. There must be a cardiac defibrillator immediately available along with a full set of medications necessary to treat all medical complications associated with ECT and general anesthesia.

PATIENT REQUIREMENTS:

ECT should only be used for the treatment of major depression, mania or catatonia. Prior to initiating ECT a comprehensive psychiatric assessment must be performed to confirm the diagnosis. Although not required, all providers are strongly encouraged to obtain a second psychiatric opinion before initiating ECT.

Patients should only be referred for ECT who have failed several medication trials or who have a potentially life-threatening emergency wherein a rapid treatment response is critical. Patients should be deemed to have failed medication trials if they have had adequate trials of at least 2 newer generation antidepressants of different classes and one older generation antidepressant (unless a trial of an older generation drug is medically contraindicated).

MEDICAL CLEARANCE:

Patients must undergo a medical history, physical examination and laboratory testing prior to ECT. Although there are no absolute contraindications to ECT (outside of increased intra-cranial pressure), any medical condition that can be exacerbated by a seizure, the autonomic arousal associated with seizures, anesthetic medications or temporary paralysis should be considered relative contraindications to the procedure. An internist knowledgeable about the procedure and the medical risks involved must evaluate all patients. Consultation should be obtained for high-risk patients (e.g., obtaining a cardiology consultation for patients with significant cardiac disease). If there
is a significant medical risk to the procedure, the treating psychiatrist should directly consult with the internist/specialist to properly assess the relative risks and benefits. This assessment should be shared with the patient and family.

**INFORMED CONSENT:**

As with any medical procedure the patient (or legal guardian) must give informed consent prior to initiating treatment. The consent must be obtained verbally and confirmed in writing. The psychiatrist must document the date, time and place that consent was obtained and the individuals present. Consent must include the known risks and benefits of ECT. The risks must include complications associated with the seizure (i.e., memory loss, confusion, cardiac arrhythmias, myocardial infarction, cerebrovascular accidents) as well as complications of anesthesia (drug reactions, hypoxia, an asthma attack, pneumonia). Although competent patients can give consent on their own, it is strongly advised that family be included in the consent process and their acceptance of the procedure be documented as well.

**PROCEDURE REQUIREMENTS:**

ECT should only be performed with a brief pulse stimulus generator that can monitor the patient’s EEG. Prior to initiating treatment all patients should have sensors in place to monitor EKG, EEG, oxygen tension, blood pressure, and pulse. There should be confirmation that the patient has been medically cleared for ECT, that laboratory studies are normal or have been addressed and that the patient hasn’t had anything to eat or drink in the previous 8 hours. If there has been a hiatus since the medical clearance and/or laboratory studies the psychiatrist should confirm that there has been no significant change in the patient’s physical condition. The signed informed consent or a true copy must be present.

**STIMULUS AND ELECTRODE PLACEMENT:**

There is no consensus on the optimal initial stimulus for ECT or the optimal initial placement of the stimulus electrodes. The initial stimulus can be determined by titrating the dose up to the seizure threshold or empirically based on the patient’s age and sex. Electrodes can be placed to affect a unilateral stimulus, a bi-frontal stimulus or a bi-temporal stimulus. Once a treatment has been completed and the response determined one would adjust the stimulus according to the adequacy of the seizure and/or therapeutic response. One will adjust the electrode placement according to the therapeutic response and severity of confusion.

**NUMBER AND FREQUENCY OF TREATMENTS:**

In general, patients receive a single treatment (one seizure) three times a week until they are significantly improved, memory loss/confusion become severe, or they are deemed treatment refractory. On average, patients receive between 4 and 12 treatments with a
mean of 8. Treating psychiatrists disagree as to how many treatments should be provided before determining that a patient is treatment refractory. The range is between 10 and 20 treatments. Therefore patients should receive at least 10 treatments but no more than 20 before deciding that they won’t respond. In some patients, particularly the frail elderly, treatments may be administered twice a week to minimize confusion.

CONTINUATION AND MAINTENANCE TREATMENT:

Many individuals undergoing a course of ECT will demonstrate only a partial response or will relapse once the procedures are stopped. These individuals may be candidates for continuation or maintenance ECT. Continuation ECT involves gradually spreading out the frequency of treatments (i.e., three times a week, going to once a week, going to once every two weeks etc.) over a period of 2 to 6 months. Maintenance ECT involves administering a single treatment on a regular basis (once every 2 weeks to once every 6 weeks). Regardless of the situation, every patient should be re-evaluated every six months to assess the risks and benefits of continued ECT.

MANAGEMENT OF COMPLICATIONS:

Common complications of ECT include prolonged seizures, prolonged apnea, cardiac arrhythmias, hypertension, post-ictal agitation, delirium, headaches, and muscle pain. The treating psychiatrist must be well versed in these conditions and implement appropriate treatment strategies.
GLOBAL EXCLUSIONARY CRITERIA

The following will not be considered appropriate justification for admission to care:

1. Court ordered evaluations.
2. Marital and family problems unless resolution of such problems is considered essential to maintain progress and reduce risk of hospitalization.
3. Psychodiagnostic evaluations for mental retardation or learning disabilities unless approved in advance and considered an essential element in the plan of care.
4. Non-availability of a less restrictive level of care.
5. Treatment in lieu of incarceration in a penal institution or jail.
6. Parent’s refusal to have minor return to the home and family.
7. Parent(s) expelled a child or teen from return to the home and family.
8. Patient requires custodial care, including awaiting placement in an alternative environment or less intensive level of care.
9. Patient is homeless, indigent and/or is without social support in the absence of meeting medical necessity criteria.
10. Admission due to inability to provide emergency overnight/crisis intervention services.
OUTPATIENT TREATMENT SERVICES for AUTISM SPECTRUM DISORDERS (ASDs) -

ADMISSION CRITERIA:

1. Patient has the cognitive ability to understand and process in either individual or family/group therapy modalities.

2. Patient has the emotional stability to actively participate in either individual or family/group therapies.

3. Patient has the capacity to develop and implement skills and strategies that will enable them to function more independently.

4. Patient has some limitation(s) within their social support systems.

Limitations in resources, in and of themselves, are not a basis for treatment. Court ordered, non-medically necessary treatment is also not a basis for treatment.

GLOBAL INDICATORS:

1. The patient has been diagnosed with an Autism Spectrum Disorder (Autistic disorder, Asperger’s Disorder, or Pervasive Developmental Disorder) as evidenced by an evaluation by a pediatrician, neurologist, child psychiatrist or a psychologist/ Master’s level counselor specializing in ASDs to exclude other conditions that may mimic ASDs and to confirm the diagnosis of ASD.

2. The patient has one or more specified behavioral disturbances that is/are amendable to short term intervention and/or require(s) ongoing treatment to prevent deterioration.

3. Professional intervention is considered likely to be effective and is essential to patient improvement and prevention of regression or deterioration.

SEVERITY OF ILLNESS

An objective professional evaluation of the patient’s current condition indicates a level of severity appropriate to outpatient services as evidenced by one or more of the following:

**Impairment in Safety:** Patient presents levels of risk to self and others that can be adequately managed in an outpatient setting.

**Impairment in Self Care:** Patient has an adequate support system to assure that any limitations in self-care will be addressed.
Impairment in Social Functioning: Impairment in interpersonal functioning is not sufficient to preclude benefit from treatment.

Complicating Conditions: There are no other complicating conditions that preclude benefit from treatment.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

By definition, patients with autism spectrum disorders often lack the personal and social resources necessary for recovery.

Exclusions: The inability to obtain necessary care, in and of itself, is not sufficient justification for treatment.

INTENSITY OF SERVICE ELEMENTS:

Within outpatient care the patient should be receiving the following services as further justification of the admission:

1. The primary service provider will have specialty training in Autism Spectrum Disorders, and will have the capacity to coordinate care with other health care providers, schools, and social service agencies as needed.
2. Medication evaluation, if necessary, for psychiatric/behavioral symptoms that may or may not be a part of the ASD.
3. Integrated and coordinated services that include family, the school, social service agencies, the pediatrician and all other educational/behavioral/medical treatment providers.
4. A behavioral treatment plan will be developed that addresses specific deficits in behavior, communication and language.
5. This treatment plan:
   a. Identifies specific behaviors that will be addressed along with record keeping that indicates progress towards reducing the frequency of problem behaviors.
   b. Defines the frequency of individual and family sessions.
   c. Delineates all individuals who will be providing care along with their responsibilities.
   d. Medication trials, if included, must specify behavioral goals that can demonstrate efficacy.
   e. Demonstrates oversight by an MHNet approved treatment provider (psychiatrist, psychologist or master’s level therapist).
CONTINUED STAY CRITERIA:

Patients being treated for ASDs will be evaluated for continuing care every three months. Continuing care will be contingent on:

1. Active participation of family/caretakers in the treatment plan.
2. Continuing progress towards achieving behavioral goals or the maintenance of goals that would deteriorate without continuing treatment.
3. Evidence of ongoing coordination of care and integration with the patient’s educational program.
4. Updated treatment plans (required every six months) including types and frequency of treatment.
5. Parents must be learning and applying ABA techniques for patient’s home environment, with a goal of ability to implement behavioral training procedures with 80% accuracy.

DISCHARGE CRITERIA:

1. Behavioral goals have been achieved and there is expectation they will be sustained without continuing treatment.
2. Failure of family/caretakers to participate in treatment.
3. Failure of the MHNet treatment provider to coordinate care with the patient’s school and/or other treatment providers.
4. Failure to demonstrate positive response to treatment.
PARTIAL HOSPITALIZATION / DAY TREATMENT PROGRAMS
FOR AUTISM SPECTRUM DISORDERS

PROGRAM DEFINITION:

This level of care is intended to be an alternative to Acute Psychiatric Inpatient treatment. The level of acuity of patients’ symptoms, intensity of services and length of stay guidelines should all be similar to those of Acute Psychiatric Inpatient treatment.

To qualify as a Partial Hospitalization / Day Treatment program, the patient must receive six to eight hours per day of individual and group therapy. The patient must participate in such a structured program at least three days per week.

ADMISSION CRITERIA:

1. Patient has the cognitive ability to understand and process in both individual and group/family therapy modalities.

2. Patient has the emotional stability to actively participate in both individual and group/family therapies.

3. Patient has the capacity to develop and implement skills and strategies that will enable them to function more independently.

4. Patient has some limitation(s) within their social support systems.

Limitations in resources, in and of themselves, are not a basis for treatment. Court ordered, non-medically necessary treatment is also not a basis for treatment.

GLOBAL INDICATORS:

1. The patient has been diagnosed with an Autism Spectrum Disorder (Autistic disorder, Asperger’s Disorder, or Pervasive Developmental Disorder) as evidenced by an evaluation by a pediatrician, neurologist, child psychiatrist or psychologist/Master’s level counselor specializing in ASD’s to exclude other conditions that may mimic ASDs and to confirm the diagnosis of an ASD.

2. The patient has one or more specified behavioral disturbances that is/are amendable to short term intervention and/or require(s) ongoing treatment to prevent deterioration.
3. Professional intervention is considered likely to be effective and is essential to improvement and prevention of regression or deterioration.

4. Alternative levels and locations of care, such as outpatient care have been attempted or seriously considered and rejected as clinically insufficient to meet the patient’s needs.

**SEVERITY OF ILLNESS:**

An objective, professional evaluation of the patient’s current condition indicates an acute level of severity appropriate to partial hospitalization as evidenced by the following:

**Impairment in Safety:** Patient may be experiencing behavior that is harmful to self or others. Patient may not be able to contract for safety, but must have a social support system in place when outside of the Day Treatment / Partial Hospital setting. Clinical evidence indicates that a less intensive outpatient setting is not appropriate.

**Impairment in Self-Care:** Patient may be experiencing noticeable impairment in ADLs when compared to baseline functioning (i.e., previously established patterns of personal hygiene, dressing, eating, toileting). Patient may be experiencing significant impairment in their eating and/or sleeping patterns.

**Impairment in Reality Orientation:** The patient may experience disturbances in their thought processes, but possesses the cognitive ability to distinguish between those and reality.

**Impairment in Social Functioning:** This level of care is considered appropriate for patients who are unable to function in unmonitored social/occupational settings. Patient’s acute symptoms may disable them from fulfilling age appropriate social/educational/occupational roles and responsibilities. The patient may be exhibiting/verbalizing a noticeable decrease (from baseline measures) in personal interactions. Patient can benefit from continuing involvement with family/social support systems.

**Complicating Conditions:** This level of care is appropriate for patients with a demonstrated need for intensive pharmacological intervention. Biomedical complications are minimal or manageable within the Partial Hospitalization/Day Treatment setting, coexisting psychological problems (e.g., depression) will not significantly interfere with partial hospital care and complications from pharmacological intervention are considered manageable.
Exclusion – Unless medically necessary, court-ordered treatment is considered an exclusion.

LIMITATIONS IN PERSONAL AND/OR SOCIAL RESOURCES:

Patient presents with limitations in resources to resolve presenting problems as indicated by:

Limited Social Resources: Patient has adequate social support system, including a suitable environment outside of the program to provide context for successful partial hospital treatment. The patient’s family must be willing and available to assist the patient outside of the Partial Hospital / Day Treatment setting, and within the Partial Hospital / Day Treatment setting when clinically indicated. Patient has a system of social support able to provide for whatever transportation needs are required by the program.

Exclusion -
1. Limitations in resources, in and of themselves, are not sufficient justification for admission.
2. In the child/adolescent population, the need for an alternative academic setting in and of itself is not sufficient justification for admission.

INTENSITY OF SERVICE ELEMENTS:

Within the Partial Hospitalization / Day Treatment Program, the patient should be receiving the following services as further justification of the admission:

1. A comprehensive evaluation must be completed within four service days of admission. This evaluation must include an initial treatment plan, tentative discharge plan, and a comprehensive family assessment.
2. The provision of services to meet the patient’s individualized academic needs.
3. A comprehensive individualized treatment plan with specific goals and intervention plans will be formed.

Such treatment plan:
   a. Identifies specific behaviors that will be addressed along with record keeping that indicates progress towards reducing the frequency of problem behaviors
   b. Defines the frequency of individual and family sessions.
   c. Delineates all individuals who will be providing care along with their responsibilities.
   d. Medication trials, if included, must specify behavioral goals that can demonstrate efficacy.
   e. Demonstrates oversight by an MHNet approved treatment provider (psychiatrist, psychologist or master’s level provider).
4. A structured activity schedule with focused individual, family, and group therapy.
5. Plan exists for management of crisis episodes if they were to occur.
6. Linkages with appropriate support groups (e.g., Autism Speaks, TACA, or USAAA).
7. A psychiatrist must be available as appropriate, providing ongoing medication monitoring and adjustment as needed.
8. Family involvement within the Partial Hospital / Day Treatment setting, including family therapy, to provide training for procedure implementation in the home. Parent(s) should be able to implement behavioral training procedures with a minimum of 80% accuracy. Family therapy should occur weekly after the initial treatment plan is developed, unless frequent family involvement would result in clinical exacerbation of the patient’s psychiatric illness.

CONTINUED STAY CRITERIA:

In order to justify remaining in a partial hospitalization program, the patient must continue to manifest symptoms related to the principal DSM-IV diagnosis and the following:
1. Admission criteria must be met.
2. Clinical documentation reflects the patient’s active progress toward treatment goals.
3. Clinical documentation supports justification that a less restrictive level of care would result in exacerbation of the patient’s psychiatric illness.
4. Family involvement is appropriate to the goal of sustaining the progress that is being made.
5. Family is actively participating in aftercare planning.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:
   (a) Completes the treatment plan.
   (b) Impairment in functioning can be managed with ongoing outpatient treatment.
   (c) Patient leaves AMA.
   (d) Patient or family refuses treatment and/or the problems that prompted admission are found not to be amenable to acute treatment.
STRUCTURED INTENSIVE OUTPATIENT PROGRAM FOR AUTISM SPECTRUM DISORDERS

PROGRAM DEFINITION:

To qualify as an intensive outpatient program the patient must receive at least 3 to 4 hours per day of individual and/or group therapy. The patient must participate in treatment at least three days per week.

ADMISSION CRITERIA:

1. Patient has the cognitive ability to understand and process in both individual and group/family therapy modalities.

2. Patient has the emotional stability to actively participate in both individual and group/family therapies.

3. Patient has the capacity to develop and implement skills and strategies that will enable them to function more independently.

4. Patient has some limitation(s) within their social support systems.

Limitations in resources, in and of themselves, are not a basis for treatment. Court ordered, non-medically necessary treatment is also not a basis for treatment.

GLOBAL INDICATORS:

1. The patient has been diagnosed with an Autism Spectrum Disorder (Autistic disorder, Asperger’s Disorder, or Pervasive Developmental Disorder) as evidenced by an evaluation by a pediatrician, neurologist, child psychiatrist or psychologist/master’s level counselor specializing in ASDs to exclude other conditions that may mimic ASDs and to confirm the diagnosis of ASD.

2. The patient has one or more specified behavioral disturbances that is/are amendable to short term intervention and/or require(s) ongoing treatment to prevent deterioration.

3. Professional intervention is considered likely to be effective and is essential to patient’s improvement and prevention of regression or deterioration.

4. Alternative levels and locations of care, such as outpatient care have been attempted or seriously considered and rejected as clinically insufficient to meet the patient’s needs.
SEVERITY OF ILLNESS:

An objective professional evaluation of the patient's current condition indicates a level of severity appropriate to IOP as evidenced by the following:

**Impairment in Safety:** The patient can be safely managed in an IOP setting.

**Impairment in Self Care:** The patient may be experiencing noticeable impairment in ADLs compared to baseline (i.e., previously established patterns of personal hygiene, dressing, eating, toileting). Patient may be experiencing significant disturbances in their eating and/or sleeping patterns.

**Impairment in Reality Orientation:** The patient may experience disturbances in their thought processes, but possesses the cognitive ability to distinguish between those and reality.

**Impairment in Social Functioning:** The patient may be exhibiting/verbalizing a noticeable decrease (from baseline measures) in personal interactions. Patient may be displaying some signs of anhedonia. Patient may be experiencing difficulty fulfilling age appropriate roles and responsibilities (i.e., educational tasks, chores). Social and occupational functioning is at a level that will permit success of an IOP program. Patient will benefit from continuing involvement with family/significant others and at work during treatment.

**Complicating Conditions:** Physiological complications are minimal, and any coexisting psychological problems (e.g., depression) will not significantly interfere with IOP services. Care and complications from pharmacological intervention are considered manageable.

INTENSITY OF SERVICE ELEMENTS:

Within IOP, the patient should be receiving the following services as further justification of the admission:

1. A comprehensive evaluation must be completed and documented within four service days of admission. This evaluation must include an initial treatment plan, a tentative discharge plan, and a family assessment.

2. A comprehensive individualized treatment plan with specific goals and intervention plans will be developed.

Such treatment plan:

   a. Identifies specific behaviors that will be addressed along with record keeping that indicates progress towards reducing the frequency of problem behaviors.
   b. Defines the frequency of individual and family sessions.
c. Delineates all individuals who will be providing care along with their responsibilities.
d. Medication trials, if included, must specify behavioral goals that can demonstrate efficacy.
e. Demonstrates oversight by an MHNet approved treatment provider (psychiatrist, psychologist or master’s level counselor).

3. A structured activity schedule with focused individual, family, and group therapy.
4. Plan exists for management of crisis episodes if they were to occur.
5. Linkages with appropriate support groups if applicable (e.g., Autism Speaks, TACA, or USAAA).
6. An independently certified behavioral health professional must be available every day of treatment providing daily supervision of care.
7. A Psychologist or Board Certified Behavior Analyst will oversee the program and be involved in the development of individual treatment plans.

CONTINUED STAY CRITERIA:

In order to justify remaining in an IOP program, the patient must continue to manifest symptoms justifying the principal DSM-IV diagnosis and the following:

1. Adequate progress is taking place, goals are being approximated and longer stay is essential to achieve goals.
2. Patient is being stabilized and maintained in a way that avoids hospitalization.
3. Patient is cooperating with caregivers and actively involved in care as evidenced by documentation of participation and attendance.
4. Family involvement is appropriate to the goal of sustaining the progress that is being made.
5. Aftercare planning is taking place and the patient and family are involved in those plans.
6. Patient has consistent attendance.

DISCHARGE CRITERIA:

The patient is ready for discharge when they satisfy any of the following criteria:

  a) Completes the treatment plan.
  b) Impairment in functioning can be managed with ongoing outpatient treatment.
  c) Patient leaves AMA.
  d) Patient or family refuses treatment, and/or the problems that prompted admission are found to be refractory or chronic.
e) Patient does not have consistent pattern of compliance with attendance prescribed in the treatment plan.