



Medical Necessity Criteria

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New Directions Behavioral Health
P.O. Box 6729
Leawood, KS 66206-0729
www.ndbh.com

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Introduction

New Directions Behavioral Health (“New Directions”) is a limited liability company founded in 1994. Our products include managed behavioral health care, employee assistance, organizational consulting, and health coaching. We are accredited by the National Committee on Quality Assurance (“NCQA”) as a Managed Behavioral Health Organization (“MBHO”) and by the Utilization Review Accreditation Commission (“URAC”) for health utilization management and case management. Our mission is to improve health through change.

New Directions believes that high quality and appropriate behavioral health care services should follow the six aims for health care based on the Institute of Medicine. Services provided should be safe, timely, effective, efficient, equitable, and patient-centered. Additionally, we embrace the “Triple Aim” for health care:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Medical Necessity

New Directions defines “Medical Necessity” or “Medically Necessary” as health care services rendered by a provider exercising prudent clinical judgment, which are:

- A. Consistent with:
 1. The evaluation, diagnosis, prevention, treatment or alleviation of symptoms of an illness, disease or injury defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM)
 2. Generally accepted standards of medical practice, as defined by credible scientific evidence published in peer-reviewed medical literature, which are generally recognized by the appropriate medical community, Physician Specialty Society recommendations and other relevant factors
- B. Clinically appropriate and designed to meet the individualized needs of the patient with regard to type, frequency, extent, site and duration of services
- C. Considered effective to improve symptoms associated with the patient’s illness, disease, injury or deficits in functioning
- D. Provided at the least restrictive and most clinically appropriate service or level of care to safely, effectively, and efficiently meet the needs of the patient
- E. Required for reasons other than the convenience of the patient, family/support system, physician or other health care provider
- F. Not a substitute for non-treatment services addressing environmental factors
- G. Not more costly than an alternative service or services, which are at least as likely to produce equivalent diagnostic or therapeutic results for the patient’s illness, disease or injury

An internal committee of behavioral health practitioners and psychiatrists developed the Medical Necessity Criteria (“Criteria” or “MNC”) contained in this document. A panel of external, practicing behavioral health clinicians and psychiatrists review and approve these criteria on an annual basis. New Directions’ Criteria are based on current psychiatric literature; pertinent documents from professional associations such as the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Society for Addiction Medicine; and other relevant sources of information, such as the National Institute of Mental Health, Agency for Healthcare Research and Quality, Substance Abuse and Mental Health Services Administration, and others. The MNC are also reviewed and approved by New Directions’ Quality Management Committee and Chief Medical Officer on an annual basis.

The Criteria are guidelines used by utilization management staff to make benefit determinations. They are not intended to replace prudent clinical judgment. New Directions recognizes that the Criteria are not exhaustive and will not cover all potential clinical situations. A physician or peer clinical reviewer will review all exceptions based on generally accepted standards of good medical practice.

The Criteria are intended for use with multiple health plans and benefit structures. New Directions administers each benefit as designed by the health plan and set out in the member's benefit agreement. The presence of a specific level of care Criteria within this set does not constitute the existence of a specific benefit. Providers and facilities should always verify the member's available benefits online when available, or by contacting the applicable Customer Service department.

Using the Medical Necessity Criteria

The Criteria are divided into four primary sections:

1. **Intensity of Services** means the intensity of services being provided, as well as services that may potentially be needed to provide an appropriate full spectrum of medical treatment, and the qualifications and licensure of the treating provider(s) or facility.
2. **Admission Criteria** means the symptoms, behaviors, or functional impairments exhibited by the member for the initial service request.
3. **Continued Stay Criteria** means the symptoms, behaviors, or functional impairments exhibited by the member for concurrent service requests.
4. **Benefit denial Criteria** means the clinical information provided does not indicate that the service requested is medically necessary or likely to be successful in treating the individualized needs of the member.

Upon receiving a service request, New Directions makes benefit determinations based on the clinical information provided by the treating provider or facility. New Directions expects an appropriately trained behavioral health professional to obtain clinical information through a face-to-face evaluation of the member, and to provide that information to New Directions when making a service request. When contacting New Directions, the treating provider or facility should present clinical information that supports the specific requested level of care. The treating provider or facility should provide clinical information in support of initial requests for Inpatient treatment within 24 hours of either the member's admission or the initial request for services. The treating provider or facility should provide clinical information in support of Residential Treatment Programs, Partial Hospitalization Programs, and Intensive Outpatient Programs at the initial request for services. It is in the interest of the provider and member to notify New Directions of any service request prior to beginning a treatment, as this will allow for clarifications about benefits available, possible non-covered services and potential requirements for claims payment.

New Directions will review the clinical information received based on the Criteria contained in this document. If the clinical information initially provided supports the medical necessity of the requested service, New Directions will approve the service request, and will review additional requests for continued stay as needed. If at any time the clinical information presented does not support the medical necessity of the requested service, New Directions will refer the request to a physician or other appropriate peer clinical reviewer for determination of medical necessity. All reviews for medical necessity will occur in compliance with applicable statutory, regulatory and accreditation standards.

New Directions makes determinations of medical necessity for benefit determination purposes only. The treating provider, in collaboration with the member, is responsible for any treatment decisions regarding the initiation or continuation of a specific service.

Throughout the MNC, there are references to physician extenders. Physician extenders are clinicians who support physicians. They are supervised by the licensed MD. As these provider types vary from state to state, it is difficult to define precisely which type of clinician would be acceptable to engage in these supportive roles, but typical physician extenders include physician assistants (PA), Advance Practice RNs (APRN), and Clinical Nurse Specialists (CNS). New Directions approves the use of physician extenders only when consistent with current state regulation and law. The approval by New Directions of a physician extender to provide service does not guarantee that New Directions will credential these individuals for in-network status. A clinician who wishes to be in-network must be licensed for independent practice, and meet current network standards and qualifications.

Additionally, the admissions and continued stay criteria contained herein refer to certain types of care. New Directions defines these care types as follows:

Custodial Care:

This is care that does not require access to the full spectrum of services performed by licensed health care professionals that is available 24 hours-a-day in facility-based settings to avoid imminent, serious, medical or psychiatric consequences. In determining whether a person is receiving custodial care, we consider the level of care and medical supervision required and furnished, and whether the treatment is designed to improve or maintain the current level of function. We do not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

By “facility-based,” we mean services provided in a hospital, long-term care facility, extended care facility, skilled nursing facility, residential treatment center (RTC), school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long-term care can also be provided in the patient’s home, however defined.

Custodial or long-term care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube or gastrostomy), exercising or dressing
2. Homemaking, such as preparing meals or special diets
3. Moving the patient
4. Acting as companion or sitter
5. Supervising medication that can usually be self-administered
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature and respiration; or administration and monitoring of feeding systems

Respite Care: care that provides respite for the member’s family or persons caring for the individual.

Domiciliary Care: care provided because care in the patient’s home is not available or is unsuitable.

Interpersonal Care: interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement

Social Care: constant observation to prevent relapse during earliest phase of detoxification. There is no medical component. This service is delivered by peers, not qualified health care professionals.

Behavioral Health Care Treatment Expectations

The service provided must reasonably be expected to improve symptoms associated with the member's diagnosis, whether secondary to illness, disease, injury, or deficits in functioning, and consistent with generally accepted standards of medical practice. These standards of medical practice include credible scientific evidence published in peer-reviewed medical literature, generally recognized by the appropriate medical community, physician specialty Society recommendations, and other relevant factors. The treating provider or physician should provide timely, appropriate, and evidence-based treatment (where available). New Directions expects that treatment provided in an inpatient, residential, partial hospital, or intensive outpatient service setting will include active medication adjustments. If no medication is prescribed during these services, the treating provider or physician must document and present the rationale, consistent with evidence-based practices.

Every clinical practice guideline recommends that family members and other support systems participate in the member's treatment. New Directions expects that the facility and attending physician or professional provider make every reasonable effort to involve and coordinate care with the member's family and support system. This includes providing or referring for necessary family therapy.

Coordination of care with other medical and behavioral professionals is another component of clinical practice guidelines. New Directions expects that the treating facility, attending physician, or professional provider make every reasonable effort to coordinate care with the member's current treating providers (therapist, psychiatrist, primary care physician, etc.) and the patient's previous treating providers, when available and appropriate, or upon readmission. This should be pursued whenever there is a substantial change in the member's condition, or approximately every two months, whichever occurs first.

Active discharge planning is vital to prevent readmission to higher levels of care and to improve community tenure. The treating facility and attending physician or professional provider should begin discharge planning at admission and continue throughout the treatment period. To be effective, the discharge plan should be developed in conjunction with the member and the member's family and support systems. The treating facility and attending physician or professional provider should address the member's continuing care needs (ambulatory appointments, medications, etc.) and any economic and transportation issues, referring to community-based resources or services, as needed.

Any questions, comments about the content of the Medical Necessity Criteria should be directed to:

Dr. Aron Halfin MD
Senior Vice President and Chief Medical Officer
New Directions Behavioral Health
8140 Ward Parkway, Suite 500
Kansas City, MO 64116
Telephone: (816) 994-1576
Email: ahalfin@ndbh.com

Psychiatric Acute Inpatient Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. The hospital or inpatient unit is licensed by the appropriate agency.
2. There is documentation of the member's history and physical examination with medical clearance is completed within 24 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 24 hours of admission and the physician or physician extender provides daily face-to-face evaluation services with documentation. The physician must be available 24 hours a day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 24 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. There is on-site registered nursing care available 24 hours a day with full capabilities for all appropriate interventions in medical and behavioral health emergencies that occur on the unit.
7. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend, unless the facility network contract specifies different treatment time requirements.
8. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
9. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 48 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than twice per week.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

Must meet 1, 2, and 3 and at least one of 4-9:

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. Acute suicidal risk is present, documented by either:
 - a. Current threat that includes a substantially lethal plan with the means and intent to enact said plan

- b. Attempt to harm self through an action of substantial lethality in the recent period prior to admission with continued suicidal intent
- 5. Acute homicidal risk is present, documented by either:
 - a. Current threat that includes identified victim(s) and a substantially lethal plan with means and intent to enact said plan
 - b. Substantial harm done to others in the recent period prior to admission with continued homicidal intent
- 6. Presence or likelihood of adverse reactions to medications or psychiatric interventions requiring 24-hour medical monitoring and management to prevent or treat serious, severe and/or imminent deterioration in the member's medical or psychiatric condition.
- 7. Onset or exacerbation of psychotic symptoms including, but not limited to, delusions, hallucinations, paranoia, and grandiosity that result in severe multiple functional disabilities that cannot be safely managed without 24-hour medical monitoring.
- 8. Acute inability to perform activities of daily living due to onset or exacerbation of symptoms, and requires 24-hour medical management and intervention to treat current dysfunctions, behaviors and symptoms.
- 9. Violent, unpredictable, uncontrollable and/or destructive behavior that cannot be safely managed without 24-hour medical management.

Continued Stay Criteria

PAI

Must meet all of the following:

- 1. A DSM diagnosis is the primary focus of active, daily treatment.
- 2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
- 3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
- 4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
- 5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
- 6. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.
- 7. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria

PAI

Must meet any of the following:

- 1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
- 2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
- 3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
- 4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Psychiatric Residential Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of the member's history and physical examination with medical clearance within 48 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission and the physician or physician extender provides face-to-face evaluation a minimum of weekly thereafter with documentation and is available 24 hours per day seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 72 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. The member is seen daily by a licensed behavioral health practitioner.
7. On-site nursing (e.g., LPNs) is available at least eight hours a day, five days per week. RNs are available 24 hours a day and will respond within one hour.
8. On-site, licensed clinical staff is available 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.
9. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend.
10. Access to psychiatric, psychological and other support services is available as needed.
11. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
12. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.

4. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least three of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self or others
5. Must have one of the following:
 - a. The member's family members and/or support system demonstrate behaviors that are likely to undermine goals of treatment, such that treatment at a lower level of care is unlikely to be successful. This lack must be situational in nature and amenable to change as a result of the treatment process and resources identified during a residential confinement.
 - b. The member has a documented recent history of an inability to be managed at an intensive lower level of care.
 - c. In the last six months, there is a history of at least several brief acute inpatient stays without a successful transition to a lower level of care, and at risk of admission to inpatient acute care.

Continued Stay Criteria

PR

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.
7. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria

PR

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Psychiatric Partial Hospitalization Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
3. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides a face-to-face evaluation with documentation as indicated, no less than weekly.
4. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
5. Treatment program includes a minimum of one member individual counseling session per week with a licensed therapist.
6. Licensed behavioral health practitioners supervise all treatment.
7. Mental health and medical services are available 24 hours per day, seven days per week, (either on-site or off-site by arrangement).
8. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days per week.
9. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
10. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
11. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within five days of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

PPH

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is documentation of risk of harm, and the member is able to develop and implement a safety plan both in the structured treatment environment and a plan (personal and professional) outside of treatment hours.

5. The member is cognitively capable to actively engage in the recommended treatment plan, **and** the member is expressing willingness to participate in the recommended treatment plan.
6. This level of care is necessary to provide structure for treatment of current symptoms:
 - a. that cannot be managed at a lower level of care, or
 - b. when current ongoing intensive outpatient care has failed to improve functioning, or
 - c. when there is a clear risk for admission to a higher level of care
7. The member needs daily structure because of at least two of the following:
 - a. Daily medication monitoring is required.
 - b. Acute coping skill deficits are severe and require daily assessment and intervention.
 - c. A crisis situation is present in social, family, work/school and/or interpersonal relationships and requires daily observation, client instruction, support and additional family interventions will be provided as needed.

Acute hopelessness and isolation is a dominant feature of clinical presentation with inadequate current supports.

Continued Stay Criteria

PPH

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active treatment each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. The member continues to needs daily structure because of at least two of the following:
 - a. Daily medication monitoring is required.
 - b. Acute coping skill deficits are severe and require daily assessment and intervention.
 - c. A crisis situation is present in social, family, work/school and/or interpersonal relationships and requires daily observation, client instruction, support and additional family interventions will be provided as needed.
 - d. Acute hopelessness and isolation is a dominant feature of clinical presentation with inadequate current supports.

Benefit Denial Criteria

PPH

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Intensity of Service***Must meet all of the following:***

1. The facility is licensed by the appropriate agency.
2. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
3. There is documentation of evaluation by a psychiatrist within one week of admission and available as indicated thereafter.
4. After a multidisciplinary assessment, and an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
5. Treatment program includes a minimum of one member individual counseling session per week with a licensed therapist.
6. Licensed behavioral health practitioners supervise all treatment.
7. Mental health and medical services are available 24 hours per day, seven days per week, (either on-site or off-site by referral).
8. Multidisciplinary treatment program that occurs a minimum of three hours per day for a minimum of three (3) days per week.
9. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
10. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
11. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within five days of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria***Must meet all of the following:***

1. A DSM diagnosis is the primary focus of active treatment each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member has the capacity to maintain safety for both self and others.
5. The member is cognitively capable to actively engage in the recommended treatment plan.
6. The member is expressing willingness to engage in recommended treatment plan.
7. This level of care is necessary to provide structure for treatment of current symptoms:
 - a. that cannot be managed at a lower level of care, or
 - b. when current ongoing outpatient care has failed to improve functioning, or

- c. when there is a clear risk for admission to a higher level of care
- 8. The individual needs structure because of two (2) of the following:
 - a. The need for monitoring less than daily but more than weekly.
 - b. Significant variability in day-to-day acute capacity to cope with life situations.
 - c. A crisis situation is present in family, work and/or interpersonal relationships and requires frequent observation and client instruction and support.
 - d. The participation in group treatment, as well as individual treatment, is required to increase support and efficacy of treatment.

Continued Stay Criteria

PIO

Must meet all of the following:

- 1. A DSM diagnosis is the primary focus of active treatment each program day.
- 2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
- 3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
- 4. There is active attendance and participation in treatment.
- 5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
- 6. The member continues to need structure because of two of the following:
 - a. The need for monitoring less than daily but more than weekly.
 - b. Significant variability in day-to-day acute capacity to cope with life situations.
 - c. A crisis situation is present in family, work and/or interpersonal relationships and requires frequent observation and client instruction and support.
 - d. The participation in group treatment, as well as individual treatment, is required to increase support and efficacy of treatment.

Benefit Denial Criteria

PIO

Must meet any of the following:

- 1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
- 2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
- 3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
- 4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Psychiatric Outpatient Criteria

Intensity of Service

Must meet all of the following:

1. Treatment is provided by either a licensed practitioner or licensed/accredited clinic and complies with generally accepted standards of care within the provider's scope of training/licensure.
2. Coordination with other behavioral and medical health providers as appropriate, but with a minimum recommended frequency of every 60 days.
3. Individualized treatment plan that guides management of the member's care. Treatment provided is timely, appropriate, and evidence-based including referral for both medical and/or psychiatric medication management as needed.
4. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
5. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within diagnostic evaluation phase of treatment with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care.
 - c. Family participation may be conducted via telephonic sessions.

Admission Criteria

Must meet items 1 - 3 and either 4 or 5:

1. A DSM diagnosis is the primary focus of active treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is documented evidence of the need for treatment to address the significant negative impact of DSM diagnosis in the person's life in any of the following areas:
 - a. Family
 - b. Work/school
 - c. Social/interpersonal
 - d. Health/medical compliance
5. The member requires ongoing treatment/intervention in order to maintain symptom relief and/or psychosocial functioning for a chronic recurrent mental health illness. Treatment is intended to prevent intensification of said symptoms or deterioration in functioning that would result in admission to higher levels of care.

If in-home therapy is requested, must additionally meet 6 - 8:

6. The member is experiencing an acute crisis or significant impairment in primary support, social support, or housing, and may be at high risk of being displaced from his/her living situation (e.g., interventions by the legal system, family/children services or higher levels of medical or behavioral health care).

7. The member requires intensive support to ensure compliance with medications and/or treatment recommendations.
8. The member is engaged with or needs assistance engaging with multiple providers and services, and needs brief intervention (including in-home services) to ensure coordination and continuity of care amongst the providers and services.

Continued Stay Criteria

POP

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately, not maintaining baseline functioning or symptom relief, or deteriorating, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms.
6. Must have one of the following:
 - a. The treatment is designed to provide relief from symptoms and to improve function in critically affected areas, such as family, social, educational, occupational or health behaviors.
 - b. The treatment is designed to stabilize a member with acute symptoms, preventing further decompensation, so that movement to a higher level of care is less likely.
 - c. This is a maintenance treatment in chronic recurrent mental health illness.
 - d. The current treatment focus is on issues of termination.

Benefit Denial Criteria

POP

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

Substance Use Disorder Inpatient Detoxification Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. The hospital or inpatient unit is licensed by the appropriate agency.
2. There is documentation of the member's history and physical with medical clearance within 24 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests upon admission, as appropriate.
4. The attending physician is a psychiatrist or addictionologist and responsible for diagnostic evaluation within 24 hours of admission. The physician or physician extender provides daily face-to-face evaluation services with documentation. The physician must be available 24 hours a day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 24 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. The need for Medication-Assisted Treatment (MAT) unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
7. There is on-site registered nursing care 24 hours a day with full capabilities for intervention in medical and behavioral health emergencies that occur on the unit.
8. Family/support system coordination, as evidenced by contact with family to discuss current treatment, as well as support needed to continue treatment at lower levels of care.
9. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
10. Individualized discharge planning begins on the day of admission and includes:
 - a. Identification of key precipitants to current episode of treatment
 - b. Assessment of psychosocial supports available after discharge
 - c. Availability of aftercare services in member's geographic area
 - d. Need for supportive, sober living placement to continue recovery
 - e. Need for services for comorbid medical or psychiatric conditions
 - f. Contact with aftercare providers to facilitate an effective transition to lower levels of care

Admission Criteria

SID

Must meet 1-4 and at least one of 5, 6, 7 or 8:

1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active, daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. The identified substance used is known to have a serious potential for morbidity or mortality during the withdrawal period including alcohol, barbiturates, and benzodiazepines.
4. Documentation of current substances used must include:
 - a. Substance used

- b. Duration of use
 - c. Frequency of use
 - d. Last date of use
 - e. Quantity used per time period
 - f. UDS or breathalyzer documentation of use
5. There are at least three signs and symptoms of active severe withdrawal are present or expectation of such within the next 48 hours, or a historical pattern of withdrawal requiring a 24-hour medical and nursing intervention to prevent potentially life-threatening consequences. Withdrawal signs include, but are not limited to:
- Temperature > 101 degrees
 - Pulse > 110 at rest and BP > 140/90
 - Hyperreflexia
 - Noticeable, paroxysmal diaphoresis at rest
 - Moderate to severe tremor at rest, as observed in outstretched arms
- Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in bullet list above.
6. History of seizures or delirium tremens (DTs) during previous withdrawal episodes
7. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care
8. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents potentially life-threatening health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.

Continued Stay Criteria

SID

Must meet 1 to 3 and at least one of 4, 5 or 6:

1. A current DSM diagnosis of substance induced disorder with withdrawal is the primary focus of active, daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge.
4. Must have at least three persistent, medically significant objective withdrawal signs, including but not limited to:
 - Temperature > 101 degrees
 - Pulse > 110 at rest and BP > 140/90
 - Noticeable, paroxysmal diaphoresis at rest
 - Hyperreflexia
 - Moderate to severe tremor at rest , as observed in outstretched arms

Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in bulleted list above.
5. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents potentially life-threatening health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.
6. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.

Note: Detoxification treatment using “fixed tapers” without documentation of serious withdrawal symptoms from substance(s) known to potentially cause serious medical morbidity will not necessarily qualify for inpatient reimbursement.

Benefit Denial Criteria

SID

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member’s current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Substance Use Disorder Residential/Subacute Detoxification Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. The facility is licensed by the appropriate agency.
2. History and physical with medical clearance within 48 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests upon admission, as appropriate.
4. The attending physician is a psychiatrist or addictionologist and responsible for diagnostic evaluation within 24 hours of admission. The physician or physician extender provides daily face-to-face evaluation services with documentation. The physician must be available 24 hours a day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 72 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
7. There is documentation that the member is seen daily by a licensed behavioral health practitioner.
8. On-site nursing (e.g., LPNs) is available at least eight hours a day, five days per week. RNs are available 24 hours a day and will respond within one hour.
9. On-site, licensed clinical staff is available 24 hours a day, seven days a week, adequate to supervise the member's medical and psychological needs.
10. Family/support system coordination as evidenced by contact with family to discuss current treatment as well as support needed to continue treatment at lower levels of care.
11. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
12. Individualized discharge planning begins on the day of admission and includes:
 - a. Identification of key precipitants to current episode of treatment
 - b. Assessment of psychosocial supports available after discharge
 - c. Availability of aftercare services in member's geographic area
 - d. Need for supportive, sober living placement to continue recovery
 - e. Need for services for comorbid medical or psychiatric conditions
 - f. Contact with aftercare providers to facilitate an effective transition to lower levels of care

Admission Criteria

SRD

Must meet 1-4 and at least one of 5, 6, 7, 8 or 9:

1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. The identified substance used is known to have a serious potential for morbidity or mortality during the withdrawal period including alcohol, barbiturates, opiates and benzodiazepines
4. Specific documentation of current substances used must include:
 - a. Substance used
 - b. Duration of use
 - c. Frequency of use
 - d. Last date of use
 - e. Quantity used per time period
 - f. UDS or breathalyzer documentation of use
5. There are at least three signs and symptoms of active severe withdrawal or expectation of such with 48 hours or a historical pattern of withdrawal requiring a 24-hour medical and nursing intervention to prevent potential consequences, either behavioral or medical.
Withdrawal signs include, but are not limited to:
 - a. Temperature > 100 degrees
 - b. Pulse > 100 at rest and BP > 140/90
 - c. Hyperreflexia
 - d. Noticeable, paroxysmal diaphoresis at rest
 - e. Mild to moderate tremor at rest, as observed in outstretched armsNote: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in the bulleted list above.
6. For Opioid withdrawal, must have at least three of the following symptoms:
 - a. Muscle aches, nausea, fever, GI cramps (which may progress to vomiting or diarrhea), dilated pupils, piloerection, runny nose, watery eyes, intense dysphoria or insomnia
7. History of seizures or delirium tremens (DT's)
8. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents significant health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.
9. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.

Continued Stay Criteria

SRD

Must meet 1 – 3 and at least one of 4, 5, 6, 7 or 8:

1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge
4. Must have at least three persistent, medically significant objective withdrawal signs, including:
 - a. Temperature > 100 degrees
 - b. Pulse > 100 at rest and BP > 140/90
 - c. Hyperreflexia
 - d. Noticeable, paroxysmal diaphoresis at rest
 - e. Mild to moderate tremor at rest, as observed in outstretched arms

Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in bulleted list above.

5. For Opioid withdrawal, must have at least three of the following symptoms:
 - a. Muscle aches, nausea, fever, GI cramps (which may progress to vomiting or diarrhea), dilated pupils, piloerection, runny nose, watery eyes, intense dysphoria or insomnia
6. Comorbid medical condition(s) that in combination with substance dependence/detoxification presents significant health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.
7. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.

Note: *Detoxification treatment using “fixed tapers” without documentation of serious withdrawal symptoms from substance(s) known to potentially cause serious medical morbidity will not necessarily qualify for residential/subacute reimbursement.*

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
2. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
3. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Substance Use Disorder Ambulatory Detoxification Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. Services provided by licensed, certified and appropriately trained personnel who can monitor withdrawal symptoms and implement physician approved protocols.
2. Evidence of drug screens and relevant lab tests at admission and as clinically indicated.
3. Access for evaluation and consultation by a licensed physician 24 hours a day.
4. Access to psychiatric and psychological and other supportive services as indicated.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within three days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member
6. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
7. Services are delivered face to face on an outpatient basis in regularly scheduled sessions.
8. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
9. Family/support system coordination as evidenced by contact with family to discuss current treatment as well as support needed to continue treatment at lower levels of care.

Admission Criteria

SAD

Must meet all of the following:

1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. Specific documentation of current substances used to include:
 - a. Substance used
 - b. Duration of use
 - c. Frequency of use
 - d. Last date of use
 - e. Quantity used per time period
 - f. UDS or breathalyzer documentation of use
4. Signs and symptoms of active withdrawal or expectation of such within 48 hours or a historical pattern of withdrawal.
5. Member has expressed a commitment to ongoing care to address the underlying substance abuse/dependency issues but needs motivating and monitoring strategies.
6. Member has sufficient coping skills and motivation for outpatient detoxification to succeed.
7. Environment is supportive and/or member has the skills to cope with environment.
8. If a psychiatric disorder is present, the member is stable and receiving adequate current treatment.

Continued Stay Criteria

SAD

Must meet all of the following:

1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions regarding risk of relapse without objective clinical evidence are not sufficient to meet this criterion.
7. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge.

Benefit Denial Criteria

SAD

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
2. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
3. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Substance Use Disorder Inpatient Rehabilitation Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. The hospital or inpatient unit is licensed by the appropriate agency.
2. There is documentation of the member's history and physical with medical clearance within 24 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
4. The attending physician is a psychiatrist or addictionologist and is responsible for diagnostic evaluation within 24 hours of admission. The physician or physician extender provides daily face-to-face evaluation services with documentation. The physician must be available 24 hours a day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 24 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
7. The member is seen daily by a licensed behavioral health practitioner.
8. There is on-site registered nursing care available 24 hours a day with full capabilities for intervention in medical and behavioral health emergencies that occur on the unit.
9. There is licensed clinical staff available on-site 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.
10. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend
11. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 48 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than twice per week.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
13. Individualized discharge planning begins on the day of admission and includes:
 - a. Identification of key precipitants to current episode of treatment
 - b. Assessment of psychosocial supports available after discharge

- c. Availability of aftercare services in member's geographic area
- d. Need for supportive, sober living placement to continue recovery
- e. Need for services for comorbid medical or psychiatric conditions
- f. Contact with aftercare providers to facilitate an effective transition to lower levels of care

Admission Criteria

SAI

Must meet 1-5 and either 6 or 7

- 1. A DSM diagnosis of substance use disorder, which is the primary focus of active daily rehabilitation treatment.
- 2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
- 3. Active substance abuse/dependency behavior within one week of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
- 4. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
- 5. The member is able to actively participate in his/her substance use disorder treatment.
- 6. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the inpatient level of care.
- 7. Member has marked medical morbidity from substance use disorder requiring active daily medical evaluation and management, not merely observation.

Continued Stay Criteria

SAI

Must meet 1-8 and at least one of 9, 10 or 11:

- 1. A DSM diagnosis of substance use disorder, which is the primary focus of active daily treatment.
- 2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
- 3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
- 4. The member is able to actively participate in his/her substance use disorder treatment.
- 5. There is compliance with all requirements of the treatment plan, unless clinically precluded.
- 6. A member's readiness for change and identified barriers to change are documented and addressed with appropriate therapeutic interventions.
- 7. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
- 8. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge.
- 9. Despite intensive therapeutic efforts and compliance with the treatment plan, continued behaviors and symptoms require this level of care. This includes treatment readiness or lack of recognition of disease effects so that termination of treatment may result in potentially dangerous consequences. Subjective opinions regarding risk of relapse without objective clinical evidence are not sufficient to meet this criterion.
- 10. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the inpatient level of care.
- 11. Member has marked medical morbidity from substance use disorder requiring active medical evaluation and management, not merely observation, and the member must be able to actively participate in his/her substance use disorder treatment.

Note: Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography, etc.) is not the sole reason for continued stay in the program.

Benefit Denial Criteria

SAI

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan. As a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Substance Use Disorder Residential/Subacute Rehabilitation Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. The facility is licensed by the appropriate agency.
2. There is documentation of the member's history and physical with medical clearance within 48 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
4. The attending physician must be a psychiatrist or addictionologist and responsible for diagnostic evaluation within 48 hours of admission. The physician or physician extender provides a minimum of weekly evaluation services with documentation. The physician must be available 24 hours a day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within three days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member
6. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
7. The member is seen daily by a licensed behavioral health practitioner.
8. On-site nursing (e.g., LPNs) is available at least eight hours a day, five days per week. RNs are available 24 hours a day and will respond to significant clinical events within one hour.
9. On-site, licensed clinical staff is available 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.
10. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend
11. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 48 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than twice per week.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
13. Individualized discharge planning begins on the day of admission and includes:
 - a. Identification of key precipitants to current episode of treatment
 - b. Assessment of psychosocial supports available after discharge

- c. Availability of aftercare services in member's geographic area
- d. Need for supportive, sober living placement to continue recovery
- e. Need for services for comorbid medical or psychiatric conditions
- f. Contact with aftercare providers to facilitate an effective transition to lower levels of care

Admission Criteria

SAR

Must meet 1 - 6 and at least one of 7,8, 9 or 10:

1. A DSM diagnosis of substance use disorder, which is the primary focus of active daily rehabilitation treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member is able to actively participate in his/her substance use disorder treatment
5. Active substance abuse/dependency behavior within one week of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
6. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least three of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self or others
7. There are acute psychiatric symptoms or cognitive deficits of moderate to severe intensity that require concurrent mental health treatment at the RTC level of care.
8. The member's environment and support system demonstrate moderate to severe lack of support and the member is unlikely to succeed in treatment at a lower level of care.
9. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs or the member has morbidity from substance use disorder and these require at least weekly medical evaluation and management.
10. This level of care is necessary to provide structure for treatment of at least one of the following;
 - a. The member has a documented very high risk for relapse (lack of support, dangerous environment, lack of skills, etc).
 - b. The member has a documented recent history of an inability to be successfully treated at an intensive lower level of care.
 - c. In the last six months, there is a history of at least several episodes of 24-hour care without a successful transition to a lower level of care, as evidenced by multiple relapses.

Continued Stay Criteria

SAR

Must meet 1 – 8 and at least one of 9 or 10:

1. A DSM diagnosis of substance use disorder, which is the primary focus of active daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member is able to actively participate in his/her substance use disorder treatment.
5. There is compliance with all aspects of the treatment plan, unless clinically precluded.

6. A member's readiness for change and identified barriers to change are documented and addressed with appropriate therapeutic interventions.
7. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
8. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge.
9. Despite intensive therapeutic efforts, this level of care is remains necessary to treat the intensity, frequency and duration of current behaviors and symptoms. This includes treatment readiness or lack of recognition of disease effects so that termination of treatment may result in potentially dangerous consequences. Subjective opinions regarding risk of relapse without objective clinical evidence are not sufficient to meet this criterion.
10. Member has marked medical morbidity from substance use disorder requiring active medical evaluation and management, not merely observation and the member must be able to actively participate in his/her substance use disorder treatment.

Note: *Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography, etc.) is not the sole reason for continued stay in the program.*

Benefit Denial Criteria

SAR

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not been completed and/or placement is pending.

Substance Use Disorder Partial Day Rehabilitation Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
3. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member
4. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
5. Licensed behavioral health practitioners supervise all treatment.
6. Mental health and medical services are available 24 hours per day, seven days per week, (either on-site or off-site by referral).
7. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days per week.
8. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
9. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.
10. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
11. Individualized discharge planning begins on the day of admission and includes:
 - a. Identification of key precipitants to current episode of treatment
 - b. Assessment of psychosocial supports available after discharge
 - c. Availability of aftercare services in member's geographic area
 - d. Need for supportive, sober living placement to continue recovery
 - e. Need for services for co-morbid medical or psychiatric conditions
 - f. Contact with aftercare providers to facilitate an effective transition to lower levels of care

Admission Criteria

SAP

Must meet 1 – 5 and at least one of 6, 7, 8, 9 or 10:

1. A DSM diagnosis of substance use disorder, which is the primary focus of active treatment each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member is able to actively participate in his/her substance use disorder treatment.
5. Active substance abuse/dependency behavior within one week of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
6. There are acute psychiatric symptoms or cognitive deficits of moderate intensity that require concurrent mental health treatment at the PHP level of care.
7. The member's environment and support system demonstrate mild to moderate lack of support, but the member can succeed in treatment with the intensity of current treatment services (30 hours/week).
8. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs or the member has morbidity from substance use disorder requiring medical evaluation and management.
9. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least two of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self or others
10. This level of care is necessary to provide structure for treatment when at least one of the following exists:
 - a. high likelihood of relapse without near daily treatment support
 - b. current ongoing intensive outpatient care has failed to improve functioning
 - c. clear risk for admission to a higher level of care

Continued Stay Criteria

SAP

Must meet 1 through 6 and at least one of 7, 8, 9 or 10:

1. A DSM diagnosis of substance use disorder, which is the primary focus of active treatment each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member is able to actively participate in his/her substance use disorder treatment.
5. There is compliance with all aspects of the treatment plan, unless clinically precluded.
6. A member's readiness for change and identified barriers to change are documented and addressed with appropriate therapeutic interventions.
7. There are acute psychiatric symptoms or cognitive deficits of moderate intensity that require concurrent mental health treatment at the PHP level of care (Criteria 4 and 7).
8. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs or the member has morbidity from substance use disorder requiring medical evaluation and management.

9. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
10. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. This includes treatment readiness or lack of recognition of disease effects so that termination of treatment may result in potentially dangerous consequences. Subjective opinions regarding risk of relapse without objective clinical evidence are not sufficient to meet this criterion.

Note: *Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography, etc.) is not the sole reason for continued stay in the program.*

Benefit Denial Criteria

SAP

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not been completed and/or placement is pending.

Substance Use Disorder Intensive Outpatient Rehabilitation Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of drug screens and other relevant lab tests upon admission and as appropriate.
3. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member
4. The need for Medication-Assisted Treatment (MAT) unless medically contraindicated, should be critically considered especially in members who have significant cravings or repeated relapses.
5. Licensed behavioral health practitioners supervise all treatment.
6. Mental health and medical services are available 24 hours per day, seven days per week (either on-site or off-site by referral).
7. Multi-disciplinary treatment program that occurs a minimum of three hours per day for a minimum of three days per week.
8. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
9. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.
10. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
11. Individualized discharge planning begins on the day of admission and includes:
 - a. Identification of key precipitants to current episode of treatment
 - b. Assessment of psychosocial supports available after discharge
 - c. Availability of aftercare services in member's geographic area
 - d. Need for supportive, sober living placement to continue recovery
 - e. Need for services for co-morbid medical or psychiatric conditions
 - f. Contact with aftercare providers to facilitate an effective transition to lower levels of care

Admission Criteria

Must meet 1- 5 and at least one of 6, 7, 8, 9 or 10

1. A DSM diagnosis of substance use disorder, which is the primary focus of active treatment each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member is able to actively participate in his/her substance use disorder treatment
5. Active substance use disorder behavior within two weeks of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
6. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care.
7. The member's environment and support systems are supportive of rehabilitation and the member can succeed in treatment with the intensity of current treatment services.
8. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs **or** the member has morbidity from substance use disorder and these require regular medical evaluation and management.
9. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least two (2) of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self of others
10. This level of care is necessary to provide structure for treatment when at least one of the following exists:
 - a. moderate likelihood of relapse without treatment structure multiple days/week
 - b. current ongoing outpatient care has failed to improve functioning
 - c. clear risk for admission to a higher level of care

Continued Stay Criteria

SAIO

Must meet 1-7 and at least one of 8, 9 or 10:

1. A DSM diagnosis of substance use disorder, which is the primary focus of active treatment each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member is able to actively participate in his/her substance use disorder treatment.
5. There is compliance with all aspects of the treatment plan, unless clinically precluded.
6. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care (Criteria 6 and 7).
7. A member's readiness for change and identified barriers to change are documented and addressed with appropriate therapeutic interventions.
8. There is documentation of member progress and compliance towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, documented evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
9. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. This includes treatment readiness or lack of recognition of disease effects so that termination of treatment may result in

potentially dangerous consequences. Subjective opinions regarding risk of relapse without objective clinical evidence are not sufficient to meet this criterion.

10. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs **or** the member has morbidity from substance use disorder requiring medical evaluation and management.

Note: *Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography, etc.) is not the sole reason for continued stay in the program.*

Benefit Denial Criteria

SAIO

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Substance Use Disorder Outpatient Rehabilitation Criteria

Intensity of Service

Must meet all of the following:

1. Treatment is provided by either a licensed practitioner or licensed/accredited clinic and complies with generally accepted standards of care within the provider's scope of training/licensure.
2. An individualized treatment plan guides management of the member's care. Treatment provided is timely, appropriate and evidence-based, including referral for both medical and/or psychiatric medication management as needed
3. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
4. Coordination with a multidisciplinary treatment team (i.e., PCP, psychiatrist and therapist) as needed and appropriate to address medical, psychiatric and substance use needs.
5. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within diagnostic evaluation phase of treatment with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.
6. Planning to transition to community resources is addressed in the treatment plan.

Admission Criteria

SAOP

Must meet 1 – 5 and either 6 or 7:

1. A DSM diagnosis of substance abuse or dependency (substance use disorder), which is the primary focus of rehabilitative treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. Active substance use disorder behavior within two weeks of the current treatment episode or at high risk for relapse.
5. Treatment is needed to develop coping skills to manage addictive behaviors to avoid movement to a higher level of care and develop relapse prevention strategies.
6. There is documented evidence of the need for treatment to address the negative impact of substance use in the person's life in any of the following areas:
 - a. Family
 - b. Work/school
 - c. Social/interpersonal
 - d. Health/medical compliance

7. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs **or** the member has morbidity from substance use disorder requiring medical evaluation and management.

Continued Stay Criteria

SAOP

Must meet 1 – 6 and either 7 or 8

1. A DSM diagnosis of substance abuse or dependency (substance use disorder), which is the primary focus of rehabilitative treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. A member’s readiness for change and identified barriers to change are documented and addressed with appropriate therapeutic interventions.
6. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member’s condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
7. There is clear progress in treatment manifested by increasing activity in multiple domains:
 - a. Increasing AA/NA attendance
 - b. Identification or increasing interaction with a sponsor
 - c. Increasingly active participation in the treatment process
 - d. Development of skills such as relapse prevention, cravings management, management of high risk situations, etc.
8. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs, or the member has morbidity from substance use disorder requiring medical evaluation and management.

Benefit Denial Criteria

SAOP

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and as a result there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member’s current behaviors and symptoms meet criteria for another level of care.
2. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
3. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Eating Disorder Acute Inpatient Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment:

1. The hospital or inpatient unit is licensed by the appropriate agency.
2. There is documentation of the member's history and physical examination with medical clearance within 24 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests (electrolytes, chemistry, CBC, thyroid, and ECG) upon admission and as appropriate.
4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 24 hours of admission and the physician or physician extender provides daily face-to-face evaluation services with documentation. The physician must be available 24 hours a day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 24 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. The facility provides a structured program staffed with licensed clinical staff who are trained and experienced in the treatment of eating disorders and preferably under the direction of a certified eating disorder specialist.
7. There is on-site registered nursing care available 24 hours a day with full capabilities for intervention in medical and behavioral health and emergencies that occur on the unit.
8. Nutritional planning with target weight range and planned interventions by a registered dietitian is undertaken.
9. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
10. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 48 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than twice per week.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

Must meet 1, 2 and 3 and at least one of 4, 5 or 6 .

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active daily treatment.
2. There is a reasonable expectation of reduction in eating disorder behaviors/symptoms with **the proposed** treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.

4. Must have one or more of the following:
 - a. The member's family members and/or support system demonstrate behaviors that are likely to undermine goals of treatment, such that treatment at a lower level of care is unlikely to be successful.
 - b. The member's family members and/or support system do not possess the requisite skills to manage the disease effectively such that treatment at a lower level of care is unlikely to be successful.
 - c. The member has a documented recent history of an inability to be managed at an intensive lower level of care.
 - d. In the last six months, there is a history of at least several brief acute inpatient stays without a successful transition to a lower level of care.
 - e. Meets at least one criteria, either 4, 5, 6, 7 or 8, for Psychiatric Acute Inpatient admission.
5. There are active biomedical complications that require 24-hour care, including but not limited to:

	Adults	Children/Adolescents
Pulse	<40	<50
Blood Pressure	<90/60	<80/50
Orthostatic changes BP AND pulse	systolic: > 20 point drop diastolic: >10 point drop	systolic: > 20 point drop diastolic: >10 point drop
Supine to standing measured with 3-minute wait	pulse: > 20 bpm	pulse: > 20 bpm
Sodium	125 meq/l	130 meq/l
Potassium	<3 meq/l	Hypokalemia
Magnesium/Phosphate	Below normal range	Below normal range
Body Temperature	<96 °F or cold blue extremities	<96 °F or cold blue extremities

6. Must have either a or b:
 - a. A body weight that can reasonably lead to instability in the absence of intervention as evidenced by one of the following:
 - i. Less than 75% of IBW or a BMI less than 15
 - ii. Greater than 10% decrease in body weight within the last 30 days
 - iii. In children and adolescents, greater than 10% decrease in body weight during a rapid growth cycle
 - b. Persistence or worsening of compensatory eating disorder behaviors despite recent (with the last three months) appropriate therapeutic intervention in a structured eating disorder treatment setting. If PHP or IOP is contraindicated, documentation of the rationale supporting the contraindication is required. One of the following must be present:

- i. Compensatory behaviors (binging, purging, laxative abuse, excessive exercise, etc.) that occur multiple times daily, have caused significant physiological complications that required urgent medical treatment.
- ii. Compensatory behaviors occur multiple times daily and have failed to respond to treatment at an intensive lower level of care.

Continued Stay Criteria

EDI

Must meet all of the following:

- 1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, daily treatment. For members significantly underweight (IBW < 85%), the expectation of weight gain of 2 pounds each week.
- 2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
- 3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
- 4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
- 5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
- 6. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.
- 7. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.

Benefit Denial Criteria

EDI

Must meet any of the following:

- 1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
- 2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
- 3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
- 4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Eating Disorder Residential Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of the member's history and physical examination with medical clearance within 48 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
3. There is documentation of drug screens and other relevant lab tests (electrolytes, chemistry, CBC, thyroid, and ECG) upon admission and as appropriate.
4. The attending physician is a psychiatrist and is responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides a face-to-face evaluation a minimum of twice per week with documentation and is available 24 hours per day, seven days per week.
5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 72 hours of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
6. The facility provides a structured program staffed with licensed clinical staff who are trained and experienced in the treatment of eating disorders and preferably under the direction of a certified eating disorder specialist. The member is seen daily by a licensed behavioral health practitioner.
7. There is on-site registered nursing care available 24 hours a day with full capabilities for intervention in medical and behavioral health and emergencies that occur on the unit.
8. On-site, licensed clinical staff is available 24-hours a day, seven days a week adequate to supervise the member's medical and psychological needs.
9. Access to psychiatric, psychological and other support services is available, as needed.
10. Nutritional planning with target weight range and planned interventions by a registered dietitian is undertaken.
11. The program progressively provides opportunities to be exposed to stressors that result or contribute to eating disorder behaviors, such as eating out, grocery store shopping, etc.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
13. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

EDR

Must meet 1 – 4 and either 5, 6 or 7:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least three of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self or others
5. Must have one of the following:
 - a. The member's family members and/or support system demonstrate behaviors that are likely to undermine goals of treatment or do not possess the requisite skills to manage the disease effectively, such that treatment at a lower level of care is unlikely to be successful.
 - b. The member has a documented recent history of an inability to be managed at an intensive lower level of care.
 - c. In the last six months, there is a history of at least several brief acute inpatient stays without a successful transition to a lower level of care and at risk of admission to inpatient acute care or the member has demonstrated an inability to be managed at an intensive lower level of care.
6. There are active biomedical complications that require 24-hour care, including, but not limited to:

	Adults	Children/Adolescents
Pulse	<40	<50
Blood Pressure	<90/60	<80/50
Orthostatic changes: BP AND pulse	systolic: > 20 point drop diastolic: >10 point drop	systolic: > 20 point drop diastolic: >10 point drop
Supine to standing measured with 3-minute wait	pulse: > 20 bpm	pulse: >20 bpm
Sodium	125 meq/l	130 meq/l
Potassium	<3 meq/l	Hypokalemia
Magnesium/Phosphate	Below normal range	Below normal range
Body Temperature	<96 °F or cold blue extremities	<96 °F or cold blue extremities

7. Must have either a. or b.:
 - a. A body weight that can reasonably lead to instability in the absence of intervention as evidenced by one of the following:
 - i. Less than 85% of IBW or a BMI less than 16.5
 - ii. Greater than 10% decrease in body weight within the last 30 days
 - iii. In children and adolescents, greater than 10% decrease in body weight during a rapid growth cycle
 - b. Persistence or worsening of compensatory eating disorder behaviors despite recent (with the last three months), appropriate therapeutic intervention in a structured eating disorder treatment setting. If PHP or IOP is contraindicated, documentation of the rationale supporting the contraindication is required. One of the following must be present:
 - i. Compensatory behaviors (binging, purging, laxative abuse, excessive exercise, etc.) that occur multiple times daily, have caused significant physiological complications that required urgent medical treatment.
 - ii. Compensatory behaviors occur multiple times daily and have failed to respond to treatment at an intensive lower level of care.

Continued Stay Criteria

EDR

Must meet all of the following:

1. A DSM diagnosis found in the Feeding and Eating Disorder is the primary focus of active, daily treatment. For members significantly underweight (IBW < 85%), the expectation of weight gain of 2 pounds each week.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.
7. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.

Benefit Denial Criteria

EDR

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and as a result there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
2. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
3. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Eating Disorder Partial Hospitalization Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of drug screens and other relevant lab tests (electrolytes, chemistry, CBC, thyroid, and ECG) upon admission and as appropriate.
3. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides a face-to-face evaluation with documentation as indicated, but no less than weekly.
4. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
5. Treatment program includes a minimum of one member individual counseling session per week with a licensed therapist.
6. The facility provides a structured program staffed with licensed clinical staff who are trained and experienced in the treatment of eating disorders and preferably under the direction of a certified eating disorder specialist.
7. Mental health and medical services are available 24 hours per day, seven days per week, (either on-site or off-site by referral).
8. The facility provides a multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days per week.
9. Nutritional planning with targeted weight range and planned interventions with a registered dietitian is undertaken.
10. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
11. The program progressively provides opportunities to be exposed to stressors that result or contribute to eating disorder behaviors, such as eating out, grocery store shopping, etc.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
13. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

EDPH

Must meet 1 - 6 and either 7, 8 or 9:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, treatment on each program day.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least two (2) of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self of others
5. The member is cognitively capable to actively engage in the recommended treatment plan, and the member is expressing willingness to participate in the recommended treatment plan.
6. Member has greater than 75% of IBW or has a BMI greater than 15.
7. The member needs daily supervision during and/or after most meals to ensure adequate nutritional intake and prevent compensatory behavior.
8. Must have one or more of the following:
 - a. The member's family members and/or support system demonstrate behaviors that are likely to undermine goals of treatment or do not possess the requisite skills to manage the disease effectively, such that treatment at a lower level of care is unlikely to be successful.
 - b. There is a clear risk for admission to a higher level of care or the member has demonstrated an inability to be managed at the next lower level of care.
9. There are biomedical complications that require physician monitoring.

Continued Stay Criteria

EDPH

Must meet all of the following:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, daily treatment. For members significantly underweight (IBW < 90%), the expectation of weight gain of 1 pound each week.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria**EDPH*****Any of the following:***

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Eating Disorder Intensive Outpatient Criteria

Intensity of Service

Must meet all of the following:

1. The facility is licensed by the appropriate agency.
2. There is documentation of drug screens and other relevant lab tests (electrolytes, chemistry, CBC, thyroid, and ECG) upon admission and as appropriate.
3. There is documentation of evaluation by a psychiatrist within one week of admission and available as indicated thereafter.
4. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.
5. Treatment program includes a minimum of one member individual counseling session per week with a licensed therapist.
6. The facility provides a structured program staffed with licensed clinical staff who are trained and experienced in the treatment of eating disorders and preferably under the direction of a certified eating disorder specialist.
7. Mental health and medical services are available 24 hours per day, seven days per week, (either on-site or off-site by referral).
8. Multi-disciplinary treatment program that occurs a minimum of three hours per day for a minimum of three days per week.
9. Nutritional planning with targeted weight range and planned interventions with a registered dietitian is undertaken.
10. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
11. The program progressively provides opportunities to be exposed to stressors that result or contribute to eating disorder behaviors, such as eating out, grocery store shopping, etc.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
13. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

EDIO

Must meet 1 – 6 and either 7, 8 or 9:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, treatment each program day. For members significantly underweight, the expectation of weight gain of 1 pound each week.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least one (1) of the following areas:
 - a. primary support
 - b. social/interpersonal
 - c. occupational/educational
 - d. health/medical compliance
 - e. ability to maintain safety for either self or others.
5. The member is cognitively capable to actively engage in the recommended treatment plan, and the member is expressing willingness to participate in the recommended treatment plan.
6. Member has greater than 80% of IBW or has a BMI greater than 15.6.
7. Must have one or more of the following:
 - a. The member's family member and/or support system demonstrate behaviors that are likely to undermine goals of treatment or do not possess the requisite skills to manage the disease effectively, such that treatment at a lower level of care is unlikely to be successful.
 - b. There is a clear risk for admission to a higher level of care or the member has demonstrated an inability to be managed at a lower level of care.
8. The member needs supervision during and/or after meals to ensure adequate nutritional intake and prevent compensatory behavior.
9. There are biomedical complications that require physician monitoring.

Continued Stay Criteria

EDIO

Must meet all of the following:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, daily treatment. For members significantly underweight (IBW < 90%), the expectation of weight gain of 1 pound each week.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria**EDIO*****Must meet any of the following:***

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Eating Disorder Outpatient Criteria

EDOP

Intensity of Service

Must meet all of the following:

1. Treatment is provided by either a licensed practitioner or licensed/accredited clinic and complies with generally accepted standards of care within the provider's scope of training/licensure.
2. Coordination with other behavioral and medical health providers as appropriate.
3. Individualized treatment plan that guides management of the member's care. Treatment provided is timely, appropriate, and evidence-based, including referral for both medical and/or psychiatric medication management as needed
4. Nutritional planning with targeted weight range and planned interventions with a registered dietitian is undertaken.
5. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within diagnostic evaluation phase of treatment with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care.
 - c. Family participation may be conducted via telephonic sessions.

Admission Criteria

EDOP

Must meet all of the following:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is documented evidence of the need for treatment to address the negative impact of the eating disorder in the person's life in any of the following areas:
 - a. Family
 - b. Work/school
 - c. Social/interpersonal
 - d. Health/medical compliance
5. The member requires ongoing treatment/intervention in order to maintain symptom relief and/or psychosocial functioning for a chronic recurrent mental health illness. Treatment is intended to prevent deterioration of said symptoms or functioning that would result in admission to higher levels of care.

Continued Stay Criteria

EDOP

Must meet all of the following:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.

3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. Must have one of the following:
 - a. The treatment is designed to provide relief from symptoms and to improve function in critically affected areas, such as family, social, educational, occupational or health behaviors.
 - b. The treatment is designed to stabilize a member with acute symptoms, preventing further decompensation, so that movement to a higher level of care is less likely.
 - c. This is a maintenance treatment in chronic recurrent mental health illness.
 - d. The current treatment focus is on issues of termination.

Benefit Denial Criteria

EDOP

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

Psychological and Neuropsychological Testing Criteria

Intensity of Service

All of the following:

1. Testing is administered and interpreted by a licensed psychologist or other qualified mental health provider (as defined by applicable State and Federal law and scope of practice). Technician administered and/or computer assisted testing may be allowed under the direct supervision of a licensed psychologist or other qualified mental health provider. Neuropsychological testing must be supervised and interpreted by a licensed psychologist with specialization in neuropsychology.
2. The requested tests must be standardized and have nationally accepted validity and reliability.
3. The requested tests must have normative data and suitability for use with the member's age group, culture, primary language and developmental level.
4. The requested time for administration, scoring and interpretation of the proposed testing battery must be consistent with the time requirements indicated by the test publisher.

Service Request Criteria

Must meet all of the following:

1. An initial face-to-face complete diagnostic assessment has been completed.
2. The purpose of the proposed testing is to answer a specific question or questions (identified in the initial diagnostic assessment) that cannot otherwise be answered by one or more comprehensive evaluations or consultations with the member, family/support system, and other treating providers review of available records.
3. The proposed battery of tests is individualized to meet the member's needs and answer the specific diagnostic/clinical questions identified above.
4. The member is cognitively able to participate appropriately in the selected battery of tests.
5. The results of the proposed testing can reasonably be expected to contribute significantly in the development and implementation of an individualized treatment plan.

Electroconvulsive Therapy (ECT): Inpatient Criteria

Intensity of Service

All of the following:

1. Meets Intensity of Service requirements 1 – 8 of the Psychiatric Acute Inpatient Criteria.
2. Meets all state laws and regulations regarding the practice of ECT.
3. The family/support system is educated as to the practice of ECT, including post-discharge care during a course of ECT treatment with attention to restrictions on daily activities, as well as the likely need for continuation of ECT on an outpatient basis, including transportation issues.

Admission Criteria

ECTI

Must meet all of the following:

1. Must have one of the following DSM diagnoses, which is the primary focus of ECT treatment:
 - a. Major Depressive Disorder: single or recurrent; severe, psychotic or non-psychotic
 - b. Bipolar Affective Disorder: depressed, mixed, manic
 - c. Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
 - d. Catatonia
 - e. Neuroleptic Malignant Syndrome
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. A complete diagnostic psychiatric evaluation is completed prior to initiation of ECT.
4. Meets criteria 4, 5, 6, 7 or 8 for Psychiatric Acute Inpatient admission.
5. Must meet one of the following:
 - a. ECT initiation requests require documentation of two or more adequate trials of full dose antidepressants (adequate time = eight weeks). Augmentation with lithium, thyroid or atypical antipsychotics has been tried or considered. Alternative indication is the inability to tolerate medication due to serious side effects. Note: Acute treatment frequency for ECT is typically three to five times per week.
 - b. Initiation of ECT to determine adverse reactions and/or interactions with medical conditions.
 - c. History of prior response to ECT with adverse reactions and/or complications of medical problems.

Continued Stay Criteria

ECTI

Must meet all of the following:

1. Must have one of the following DSM diagnoses, which is the primary focus of ECT treatment:
 - a. Major Depressive Disorder: single or recurrent; severe, psychotic or non-psychotic
 - b. Bipolar Affective Disorder: depressed, mixed, manic
 - c. Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
 - d. Catatonia
 - e. Neuroleptic Malignant Syndrome
2. Meets criteria for Psychiatric Acute Inpatient level of care or ECT resulted in significant medical complications that require continued inpatient monitoring.
3. There is compliance with all aspects of the treatment plan, unless clinically precluded.

4. There is a reasonable expectation of improvement in the acute behavior/symptom intensity with continued ECT and other treatments at this level of care.
5. Member is progressing towards treatment goals, but maximum benefit has not yet been achieved. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms.
6. Despite intensive therapeutic efforts, the current level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria

ECTI

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Electroconvulsive Therapy (ECT): Outpatient Criteria

Intensity of Service

All of the following:

1. The facility or unit is licensed by the appropriate agency.
2. The primary attending physician is a psychiatrist. The attending is responsible for diagnostic evaluation and provides face-to-face services with documentation.
3. Post-ECT follow-up care is documented and updated to reflect changes in the clinical condition.
4. Meets all state laws and regulations regarding the practice of ECT
5. The family/support system is educated as to the practice of ECT, including post-discharge care during a course of ECT treatment with attention to restrictions on activities.

Admission Criteria

Must meet 1, 2 & 3 and either 4, 5 or 6:

1. Must have one of the following DSM diagnoses, which is the primary focus of ECT treatment:
 - a. Major Depressive Disorder: single or recurrent; severe, psychotic or non-psychotic
 - b. Bipolar Affective Disorder: depressed, mixed, manic
 - c. Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
 - d. Catatonia
 - e. Neuroleptic Malignant Syndrome
2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.
3. A complete diagnostic psychiatric evaluation is completed prior to initiation of ECT.
4. ECT initiation requests at outpatient level of care require documentation of two or more adequate trials of full dose antidepressants (adequate time = eight weeks). Augmentation with lithium, thyroid or atypical antipsychotics has been tried or considered. Alternative indication is the inability to tolerate medication due to serious side effects. Note: Acute treatment frequency for ECT is typically two to five times per week.
5. History of prior positive response to ECT.
6. Must meet one of the following:
 - a. Continuation ECT: Up to six months after index episode, typical treatment frequency is individualized to sustain remission or control ongoing symptoms.
 - b. Maintenance ECT: Greater than six months after index episode, typical frequency is individualized to sustain remission or control ongoing symptoms. Treatment needs should be reevaluated every six months.
 - c. Transfer from inpatient during acute ECT series when Psychiatric Acute Inpatient criteria are no longer met and the treatments are well tolerated.

Continued Stay Criteria

Must meet all of the following:

1. Must have one of the following DSM diagnoses, which is the primary focus of ECT treatment:
 - a. Major Depressive Disorder: single or recurrent; severe, psychotic or non-psychotic
 - b. Bipolar Affective Disorder: depressed, mixed, manic
 - c. Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
 - d. Catatonia

e. Neuroleptic Malignant Syndrome

2. There is compliance with all aspects of the treatment plan, unless clinically precluded.
3. There is a reasonable expectation of improvement in the acute behavior/symptom intensity with continued ECT and other treatments at this level of care.
4. Despite intensive therapeutic efforts, the ECT at this current level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria

ECTOP

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that precipitated treatment entrance.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

23-Hour Observation Criteria	OBS
<i>Intensity of Service</i>	
<p><i>Must meet all of the following for certification of this level of care throughout the treatment:</i></p> <ol style="list-style-type: none"> 1. On-site Registered Nursing care with full capabilities for intervention in behavioral health emergencies that occur on the unit is available 24 hours per day. 2. The hospital or inpatient unit is licensed by the appropriate agency. 3. There must be a reasonable expectation that the symptoms, behavior or crisis can be resolved or stabilized within 23 hours. If the presenting symptoms, behavior or crisis cannot be or are not resolved/stabilized within 23 hours, the member must be referred to an appropriate acute inpatient facility for continued treatment. 4. There is documentation of evaluation by the attending physician within 23 hours of admission. 5. There is documentation of drug screens and other relevant lab results. 6. Treatment provided is timely, appropriate, and evidence-based (where available), and includes medication adjustments, where appropriate. Documented rationale is required if no medication is prescribed. Treatment interventions should be focused to resolve the immediate crisis within the 23-hour setting. 	
<i>Admission Criteria</i>	
OBS	
<p><i>Must meet 1 - 2 and either 3, 4, 5 or 6:</i></p> <ol style="list-style-type: none"> 1. Reasonable expectation that the presenting symptoms/behavior will adequately resolve or stabilize sufficiently to initiate treatment at a lower level of care within 23 hours. 2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care. 3. Emerging imminent risk of significant harm to self due to one of the following: <ol style="list-style-type: none"> a. Current threat that includes a plausible plan in the absence of the specific means and/or intent to enact said plan b. Current/recent attempt that included a non-lethal plan and intent with ongoing risk due to lack of remorse, poor impulse control or inability to reliably plan for safety c. Acute psychotic symptoms with disorganized or bizarre behaviors d. Violent, unpredictable, uncontrollable and destructive behavior 4. Emerging imminent risk of significant harm to others due to one of the following: <ol style="list-style-type: none"> a. Current threat that includes identified victim(s) in the absence of the specific means and/or intent to enact said plan b. Current/recent attempt that included a non-lethal plan and intent with ongoing risk due to lack of remorse, poor impulse control or inability to reliably plan for safety c. Acute psychotic symptoms with disorganized or bizarre behaviors d. Violent, unpredictable, uncontrollable and destructive behavior 5. Acute intoxication with significant medical, emotional or behavioral disturbance requiring 24-hour medical management and intervention. 6. Presence or likelihood of adverse reactions to psychiatric interventions requiring 24-hour medical monitoring and management to prevent or treat serious, severe and/or imminent deterioration in the member's medical or psychiatric condition. 	
<i>Benefit Denial Criteria</i>	
OBS	
<ol style="list-style-type: none"> 1. There is significant documented change in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care. 	

Crisis Intervention Services Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment intervention:

1. There is supervision of the member throughout the course of the Intervention.
2. There is documentation of a comprehensive assessment by a licensed mental health professional.
3. A psychiatric evaluation/medication evaluation is performed by a physician or physician extender if at the time of the comprehensive assessment it is determined that the member is in need of such an evaluation.
4. Active discharge planning should be beginning at the time services are initiated and continue throughout program participation. To be effective, the discharge plan must be developed in conjunction with the member and the family/support systems to which the member will return. The discharge plan should include the needs of the family/support system in addition to the member's continuing care needs (ambulatory appointments, medications, etc.) in order to prevent readmission. Referrals to community-based resources or services, including case management, should be included in the discharge plan.

Admission Criteria

CIS

Must meet all of the following:

1. The member has documented symptoms and/or behaviors consistent with a severe, acute behavioral health condition.
2. The member receives constant care from a primary caregiver who is in need of a brief hiatus from care-giving in order to prevent any of the following:
 - a. Abuse or neglect of the member
 - b. Disruption or loss of the member's living situation
 - c. Loss of optimal baseline functioning
3. The member is not an imminent risk of significant harm to self or others and is medically stable.
4. The member's family/caregiver is supportive of treatment and agreeable for the member to return to the home environment within 72 hours of admission to the crisis intervention service.

Benefit Denial Criteria

CIS

Must meet any of the following:

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.
4. The member no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

Community Case Management Criteria

Intensity of Service

Must meet all of the following for certification of this level of care throughout the treatment intervention:

1. Coordination of services, agencies and/or providers as needed to engage the member in appropriate therapeutic and community services to address medical, psychiatric, substance use and psychosocial needs.
2. Individualized case management plan with objective, measurable and short-term treatment goals that address current needs and relevant psychosocial factors. The case management plan must be developed in conjunction with the member and follow an assessment of psychological, psychosocial, medical and substance use needs.
3. An assessment of the home environment, family/support system and available community resources should be included in the initial evaluation.
4. Servicing provider is an independently licensed mental health professional (e.g., social worker, professional counselor, psychologist, etc.) or is providing services under the direct supervision of an independently licensed mental health professional.
5. Family participation:
 - a. For adults: If family participation is documented as a clinical need on the treatment plan, it is being utilized or there is clear documentation of reasons why family participation does not occur.
 - b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.
 - c. Family participation may be conducted via telephonic sessions when there is a significant geographic limitation.

Admission Criteria

CCM

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. The member meets Admission Criteria for Outpatient, Intensive Outpatient or Partial Hospitalization levels of care.
5. The member has had two or more admissions to higher levels of care within the past six months, or there is indication that the member is at imminent risk of readmission to higher levels of care in the absence of this intervention.
6. There is a lack of community, family and/or social support system resources to adequately meet the needs of the member in the home environment. This lack must be situational in nature and amenable to change as a result of the case management process and resources identified in the case management plan.
7. The member is engaged with or needs assistance engaging with multiple providers and services, and needs brief intervention (including in-home services) to ensure coordination and continuity of care amongst the providers and services.

Continued Stay**CCM****Must meet all of the following:**

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms with treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is compliance with all aspects of the treatment plan, unless clinically precluded.
5. There is documentation of member progress towards treatment goals. If the member is not progressing appropriately or if the member's condition has worsened, evidence of active, timely reevaluation and change of the treatment plan to address the current needs and stabilize the symptoms necessitating the admission.
6. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Benefit Denial Criteria**CCM****Must meet any of the following:**

1. Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

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