Medical Necessity Criteria

2021

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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 healthcare, employee assistance and student well-being programs. 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 healthcare services should follow the six aims for healthcare 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 healthcare:

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

Medical Necessity

Please refer to the controlling specific health plan and/or group documents for the definition of Medical Necessity.

An internal New Directions 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, Chief Clinical Officer and Chief Medical Officer on an annual basis.

The Medical Necessity Criteria are guidelines used by the New Directions Clinical Services licensed staff to decide whether to refer the service request for physician review, based upon the clinical information submitted by the facility/provider. New Directions recognizes that the Criteria is not exhaustive and may not cover all potential clinical situations. A Medical Staff physician or peer clinical reviewer will review service requests referred by Clinical Services licensed staff based on generally accepted standards of good medical practice and prudent clinical judgement. New Directions prohibits its employees, clinicians, physicians or physician consultants from receiving any financial incentive in exchange for a specific benefit determination. New Directions does not offer or solicit financial incentives to influence decisions on service requests, including benefit determinations. Every benefit determination made by New Directions or its employees, clinicians, physicians and physician consultants is made in the best interest of the individual member, and is based upon the MNC, generally accepted medical policies and the clinical judgment of the New Directions team.

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 for each level of care are divided into three primary sections:

1. The ***Intensity of Services*** section details 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. The ***Initial Authorization Request*** *section* details the documented symptoms, behaviors, or functional impairments exhibited by the member at the time of the initial service request.
3. The ***Continued Authorization Request(s)*** section details the documented present symptoms, behaviors, or functional impairments exhibited by the member at the time of the concurrent service request.

Upon receiving a service request or continued 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 legally and clinically appropriate 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.

For Acute Intensive Inpatient Hospitals, the treating provider or facility should provide complete clinical information to support initial authorization request for Inpatient treatment prior to admission. New Directions recognizes that in emergent situations this may not be possible, but certification for the care request should be requested within 24 hours of the member's admission. For Residential Treatment Programs, Partial Hospitalization Programs and Intensive Outpatient Programs, the treating provider or facility should provide complete clinical information prior to admission to support service requests at these non-emergent levels of care.

It is advisable for Providers and Facilities to notify New Directions of any service request prior to beginning treatment. Notification is in the interests of the provider, facility and member because it provides sufficient time to clarify available benefits, identify possible non-covered services and avoid potential penalties for failure to obtain precertification that might impact claims adjudication and payment.

New Directions will review the clinical information provided by the provider or facility based on the Criteria contained in this document. If the clinical information 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 the clinical information provided 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.

Definitions of Terms

Physician extenders: These are clinicians who support physicians. They are supervised by the licensed MD. These provider types vary from state to state depending on applicable state law. Typical physician

extenders may 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 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.

Current Condition: This refers to a holistic assessment of the member, taking into account the current acute symptoms, the members persisting chronic symptoms related to a past history of mental health diagnosis or diagnoses and social determinants of health status.

Respite Care: Care that provides respite for the member's family or other 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 the earliest phase of detoxification. There is no medical component. This service is delivered by peers, not qualified healthcare professionals.

Facility-Based Services: services provided in a hospital, 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.

Certified Eating Disorder Specialist: Clinicians that have obtained a certification from the International Association of Eating Disorders Professionals Foundation or the Academy for Eating Disorders.

Withdrawal Management: Refers to "detoxification."

Behavioral Healthcare Treatment Expectations

Treatment: 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 should provide timely, appropriate and evidence-based treatment (where available).

Medications: 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.

Support System: New Directions expects that the treating 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: New Directions expects that the treating facility, attending physician and/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 major change in the member's condition, or approximately every two months, whichever occurs first.

Discharge Planning: 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.

No Fail First Policy: New Directions does not endorse nor use a "fail first" policy. A "fail first" practice requires members to fail treatment at a less intensive level of care as the sole determinant to qualify for benefit approval at a higher intensity level of care. All New Directions' benefit determinations are based upon the clinical information submitted by care providers who are cognizant of the member's clinical situation, which is then reviewed with New Directions Medical Necessity Criteria.

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

Dr. Bernard DiCasimirro, Senior Vice President/Chief Medical Officer
P.O. Box 6729
Leawood, KS 66206
Telephone (816)-994-1644 | BDiCasimirro@ndbh.com

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 state agency that approves healthcare facility licensure.
2. There is documentation that 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 relevant lab tests upon admission and as clinically indicated.
4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 24 hours of admission. The physician or physician extender provides daily 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care, and other issues that affect the likelihood of successful community tenure
6. Treatment programing includes documentation of one individual counseling session weekly or more as clinically indicated.
7. There is documentation that the member is evaluated daily by a licensed behavioral health practitioner.
8. Medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. On-site registered nursing care is available 24 hours a day, seven days a week with full capabilities for all appropriate interventions in medical and behavioral health and emergencies that occur on the unit.
10. 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.
11. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs identified in the member's treatment plan.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 24 hours of admission.
13. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically

lists the contraindications to Family Therapy. 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 at least weekly or more often if clinically indicated.

c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request

PAI

Must meet 1, 2 and 3 and at least one of 4-8:

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, 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. 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.
7. 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.
8. Violent, unpredictable, uncontrollable and/or destructive behavior that cannot be safely managed without 24-hour medical management.

Continued Authorization Request(s)

PAI

Must meet all of the following: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area)

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. The member is displaying increasing motivation, interest in and ability to actively engage in his/her behavioral health treatment, as evidenced by active participation in groups,

cooperation with treatment plan, working on assignments, actively developing discharge plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.

7. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
8. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.
9. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
10. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.

Psychiatric Residential 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 state agency that approves healthcare facility licensure.
2. There is documentation that the member's history and physical examination with medical clearance is completed 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 relevant lab tests upon admission and as clinically indicated.
4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission. The physician or physician extender provides evaluation a minimum of weekly thereafter with documentation. The physician must be 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. Treatment programming includes documentation of at least one individual counseling session weekly or more as clinically indicated.
7. There is documentation that the member is evaluated daily by a licensed behavioral health practitioner.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. 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 respond to major clinical events within one hour.
10. 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.
11. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs identified in the member's treatment plan.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 72 hours of admission.
13. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly or more often if clinically indicated.

c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request

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 for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and daily 24-hour care is required to safely and effectively treat the member's current condition.
5. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 3 areas, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
6. The member is cognitively capable to actively engage in the recommended treatment plan.
7. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system that engages in behaviors that undermine the goals of treatment and adversely affects outcomes, lack of community resources, or any other factors that would impact the overall treatment outcome and community tenure.
    b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.
    c. The member is at high risk for admission to acute inpatient care secondary to multiple recent previous inpatient treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

Continued Authorization Request(s)
PR

Must meet all of the following: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis is the primary focus of active, daily treatment.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.
7. The member is displaying increasing motivation, interest in and ability to actively engage in his/her behavioral health treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively developing discharge plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
8. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
9. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Psychiatric Partial Hospitalization Criteria

Intensity of Service

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

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests upon admission and as clinically indicated.
3. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides an 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care, and other issues that affect the likelihood of successful community tenure.
5. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
6. There is documentation the member is evaluated on each day of the program by a licensed behavioral health practitioner.
7. Licensed behavioral health practitioners supervise all treatment.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by arrangement.
9. Multidisciplinary treatment program that occurs 5 days a week and provides 20 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms/problems, New Directions does not count these activities in the total hours of treatment delivered.
10. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
11. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.
13. Family participation:

a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly.
c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request
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 for improvement in the severity of the current condition and behaviors that require a minimum of twenty hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of twenty hours of treatment each week is required to safely and effectively treat the member's current condition.
5. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 2 areas, including but not limited to:
    a. potential safety issues for self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
6. The member is cognitively capable to actively engage in the recommended treatment plan.
7. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system that engages in behaviors that undermine the goals of treatment and adversely affects outcomes, lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.
    b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.
    c. The member is at high risk for admission to a higher level of care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

8. The member needs partial hospitalization because of at least two of the following reasons:
    a. The members condition or stage of recovery requires the need for daily treatment interventions in order to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care.
    b. Acute coping skill deficits are significant and require daily assessment and intervention.
    c. A crisis situation is present in social, family, work/school and/or interpersonal relationships which may require daily observation, crisis intervention services, safety planning, problem solving, social services, care coordination, client instruction, support and additional family interventions and other services that may be provided as clinically indicated.

Continued Authorization Request(s)
PPH

Must meet all of the following: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis is the primary focus of active treatment each program day.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of twenty hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.
7. The member is displaying increasing motivation, interest in and ability to actively engage in his/her behavioral health treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively developing discharge plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
8. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
9. The member continues to need partial hospitalization because of at least two of the following:

a. The members condition or stage of recovery requires the need for daily treatment interventions in order to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care.
b. Acute coping skill deficits are significant and require daily assessment and intervention.
c. A crisis situation is present in social, family, work/school and/or interpersonal relationships which may require resources such as crisis intervention services, safety planning, problem solving, social services, care coordination, client instruction, support, additional family interventions and other services that may be provided as clinically indicated.

10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Psychiatric Intensive Outpatient Criteria

Intensity of Service

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

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests upon admission and as clinically indicated.
3. There is documentation of evaluation within one week of admission by a psychiatrist who remains available as medically indicated for face-to-face evaluations.
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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care, and other issues that affect the likelihood of successful community tenure.
5. Treatment programming includes documentation of at least one individual counseling session weekly or more as clinically indicated.
6. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
7. Licensed behavioral health practitioners supervise all treatment.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. A Multidisciplinary treatment program that occurs three days per week and provides a minimum of 9 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms/problems, New Directions does not count these activities in the total hours of treatment delivered.
10. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
11. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.
13. Family participation:

a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly.
c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request

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 for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of nine hours of treatment each week is required to safely and effectively treat the member's current condition.
5. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 1 area, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
6. The member is cognitively capable to actively engage in the recommended treatment plan.
7. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including, but not limited to: medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources , or any other factors that would impact the overall treatment outcome and community tenure.
    b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.
    c. The member is at high risk for admission to acute inpatient care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

8. The individual needs intensive outpatient care because of at least two of the following:
    a. The members condition or stage of recovery requires the need for multiple treatment interventions per week in order to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care.
    b. Marked 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 which may require frequent observation, crisis intervention services, safety planning, problem solving, social services, care coordination, client instruction, support, additional family interventions and other services that may be provided as clinically indicated.

Continued Authorization Request(s)
PIO

Must meet all of the following: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis is the primary focus of active treatment each program day.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.
7. The member is displaying increasing motivation, interest in and ability to actively engage in his/her behavioral health treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively developing discharge plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
8. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
9. The member continues to need intensive outpatient care because of at least two of the following:
    a. The members condition or stage of recovery requires the need for multiple treatment interventions per week in order to stabilize the clinical condition and acquire the necessary skills to be successful in the next level of care.
    b. Marked variability in day-to-day capacity to cope with life situations.
    c. A crisis situation is present in family, work and/or interpersonal relationships which may require resources such as frequent observation, crisis intervention services, safety planning, problem solving, social services, care coordination, client instruction, support, additional family interventions and other services that may be provided as clinically indicated.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Psychiatric Outpatient Criteria

POP

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: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy,
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 or other limitation.

Initial Authorization Request

POP

Must meet items 1 - 4 and either 5, 6, 7 or 8:

1. A DSM diagnosis is the primary focus of active treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, 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. 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 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 healthcare).
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 Authorization Request(s)
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 for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, 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.

Substance Use Disorder Inpatient Withdrawal Management 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 state agency that approves healthcare facility licensure.
2. There is documentation that 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 relevant lab tests upon admission, as clinically indicated.
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 medical management and 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. The member and/or family member should be made aware of FDA-approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
7. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. On-site registered nursing care is available 24 hours a day, seven days a week, with full capabilities for all appropriate interventions in medical and behavioral health emergencies that occur on the unit.
10. 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.
11. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 24 hours of admission.

Initial Authorization Request
SUDIWM

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

1. A DSM diagnosis of substance use disorder with withdrawal, which is the primary focus of active, daily withdrawal management treatment.
2. The treatment is not primarily social, 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. 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 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 $\geq$ 100 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 are encouraged to also provide a validated scale such as CIWA or COWS
6. There is a detailed history of medical treatment for seizures/DTs documented in the medical record.
7. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating withdrawal management at a lower level of care.
8. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents potentially life-threatening health risks which require daily medical management and nursing care, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. (NOTE: Input from New Directions Medical Director is suggested.)

Continued Authorization Request(s)
SUDIWM

Must meet 1 to 6 and at least one of 7, 8 or 9: (N.B., criteria #6 should only be used when the member seeks treatment outside of their home geographic area)

1. A current DSM diagnosis of substance use disorder with withdrawal is the primary focus of active, daily withdrawal management treatment.
2. The treatment is not primarily social, 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. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.

5. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
6. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
7. Must have at least three persistent, medically significant objective withdrawal signs, including but not limited to:
    a. Temperature $\geq$ 100 degrees
    b. Pulse > 110 at rest and BP > 140/90
    c. Noticeable, paroxysmal diaphoresis at rest
    d. Hyperreflexia
    e. Moderate to severe tremor at rest, as observed in outstretched arms

    Note: Facilities are encouraged to also provide a validated scale such as CIWA or COWS.
8. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents potentially life-threatening health risks, which requires daily medical management and nursing care including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. (NOTE: Input from New Directions Medical Director is suggested.)
9. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating withdrawal management 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 service request approval.*

Substance Use Disorder Residential/Subacute Withdrawal Management Criteria	SUDRWM

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 state agency that approves healthcare facility licensure.
2. There is documentation that the member's history and physical examination with medical clearance is completed 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 relevant lab tests upon admission, as clinically indicated.
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 medical monitoring and daily 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. The member and/or family member should be made aware of FDA-approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
7. There is documentation that the member is evaluated 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. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
11. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 72 hours of admission.

Initial Authorization Request
SUDRWM

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

1. A DSM diagnosis of substance use disorder with withdrawal, which is the primary focus of active daily withdrawal management treatment.
2. The treatment is not primarily social, 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 $\geq$ 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 are encouraged to also provide a validated scale such as CIWA or COWS.
6. In the absence of an immediately available lower level of care (defined by geo-access standards) for opioid withdrawal, must have at least three of the following symptoms that are clinically significant, or these are reasonably expected within 48 hours:
    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. There is a detailed history of medical treatment for seizures/DTs documented in the medical record.
8. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents significant health risks, which require daily medical monitoring and nursing care including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. (NOTE: Input from New Directions Medical Director is suggested.)
9. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating withdrawal management at a lower level of care.

Continued Authorization Request(s)
SUDRWM

Must meet 1 – 6 and at least one of 7, 8, 9 or 10: (N.B., criteria #4 should only be used when the member seeks treatment outside of their home geographic area)

1. A DSM diagnosis of substance use disorder with withdrawal, which is the primary focus of active daily withdrawal management treatment.
2. The treatment is not primarily social, interpersonal, domiciliary or respite care.

3. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to continue and maintain treatment at lower levels of care.
4. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
5. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge.
6. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
7. Must have at least three persistent, medically significant objective withdrawal signs, including:
    a. Temperature $\geq$ 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 are encouraged to also provide a validated scale such as CIWA or COWS.
8. For opioid withdrawal, must have at least three persistent, medically significant, objective withdrawal signs including, but not limited to:
    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
9. Comorbid medical condition(s) that in combination with substance dependence/detoxification presents severe health risks, which require daily medical monitoring and nursing care including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. (NOTE: New Directions Medical Director input suggested.)
10. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating withdrawal management 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 service request approval.

Substance Use Disorder Ambulatory Withdrawal Management Criteria	SUDAWM

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. There is documentation 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 24 hours of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. The member and/or family member should be made aware of FDA-approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
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 the initial individualized treatment plan within three days of admission.

Initial Authorization Request
SUDAWM

Must meet all of the following:

1. A DSM diagnosis of substance use disorder with withdrawal, which is the primary focus of active daily withdrawal management treatment.
2. The treatment is not primarily social, 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 use disorder issues but needs motivating and monitoring strategies.
6. Member has sufficient coping skills and motivation for outpatient withdrawal management 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 Authorization Request(s)

SUDAWM

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. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
4. The treatment is not primarily social, interpersonal, domiciliary or respite care.
5. There is compliance with all aspects of the treatment plan, unless clinically precluded.
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. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions that a member has an acute and imminent risk of decompensation are supported by confirmatory objective clinical evidence.
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.

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 state agency that approves healthcare facility licensure.
2. There is documentation that 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 relevant lab tests upon admission and as clinically indicated.
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 medical management and 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure
6. The member and/or family member should be made aware of FDA-approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
7. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
8. There is documentation that the member is evaluated daily by a licensed behavioral health practitioner.
9. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 24 hours of admission.
10. On-site registered nursing care is available 24 hours a day 7 days a week with full capabilities for all appropriate interventions in medical and behavioral health emergencies that occur on the unit.
11. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by arrangement.
12. On-site licensed clinical staff are available 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.

13. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs identified in the member's treatment plan.
14. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly or more often if clinically indicated.
    c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request

SUDIR

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 for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. Active substance use within one week of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
4. The treatment is not primarily social, interpersonal, domiciliary or respite care.
5. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and daily 24-hour care is required to safely and effectively treat the member's current condition.
6. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the inpatient level of care **AND** these psychiatric services are provided in a timely manner at the appropriate intensity.
7. Member has severe medical morbidity from substance use disorder which requires daily medical management and nursing care, not merely observation.

Continued Authorization Request(s)

SUDIR

Must meet 1 -10 and at least one of 11, 12 or 13: (N.B., criteria #7 should only be used when the member seeks treatment outside of their home geographic area and #8 only if there are multiple recent admissions)

1. A DSM diagnosis of substance use disorder, which is the primary focus of active daily treatment.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The member is displaying increasing motivation, interest in and ability to actively engage in his/her substance use disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively building a relapse prevention plan and other markers of treatment engagement.

5. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
6. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
7. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
8. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change and relapse prevention interventions, and facilitates the development of recovery supports and other services to benefit the member in his/her recovery process.
9. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
10. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed health practitioner within seven days of discharge.
11. Despite intensive therapeutic efforts, this level of care remains necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions that a member has an acute and imminent risk of decompensation are supported by confirmatory objective clinical evidence.
12. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the inpatient level of care.
13. Member has severe medical morbidity from substance use disorder which requires daily medical management and nursing care, 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.

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 state agency that approves healthcare facility licensure.
2. There is documentation that the member's history and physical examination with medical clearance is completed 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 relevant lab tests upon admission and as clinically indicated.
4. The attending physician is a psychiatrist or addictionologist and responsible for diagnostic evaluation within 48 hours of admission. The physician or physician extender provides medical monitoring and 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 72 hours of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
7. The member and/or family member should be made aware of FDA-approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
8. There is documentation that the member is evaluated daily by a licensed behavioral health practitioner.
9. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
10. 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 respond to significant clinical events within one hour.
11. On-site, licensed clinical staff are available 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.
12. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs identified in the member's treatment plan.
13. Family participation:

a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly or more often if clinically indicated.
c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

14. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 72 hours of admission.

Initial Authorization Request
SUDRR

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 rehabilitation treatment.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and daily 24-hour care is required to safely and effectively treat the member's current condition.
5. The member is cognitively capable to actively engage in the recommended treatment plan.
6. Active substance use within one week of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
7. 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.
8. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 3 areas, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
9. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.
    b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being

non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.

c. The member is at high risk for admission to inpatient care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

10. There are acute psychiatric symptoms or cognitive deficits of moderate to severe intensity that require concurrent 24-hour mental health treatment **AND** these psychiatric services are provided in a timely manner at the appropriate intensity.
11. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care or the member has morbidity from substance use disorder, which requires daily medical monitoring and nursing care.

Continued Authorization Request(s)
SUDRR

Must meet 1 – 10 and at least one of 11, 12 or 13: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis of substance use disorder, which is the primary focus of active daily treatment.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, relapse prevention interventions, facilitates the development of recovery supports and other services to benefit the member in his/her recovery process.
7. The member is displaying increasing motivation, interest in and ability to actively engage in his/her substance use disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments , actively building a relapse prevention plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
8. The member's treatment plan is centered on the alleviation of disabling substance use disorder symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.

9. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed health practitioner within seven days of discharge.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the RTC level of care AND these psychiatric services are provided in a timely manner at the appropriate intensity.
12. Despite intensive therapeutic efforts, this level of care remains necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions that a member has an acute and imminent risk of decompensation are supported by confirmatory objective clinical evidence.
13. Member has severe medical morbidity from substance use disorder which requires daily medical monitoring and nursing care, 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.

Substance Use Disorder Partial Day Rehabilitation Criteria

Intensity of Service

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

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests upon admission and as clinically indicated.
3. After a multidisciplinary assessment, an individualized treatment plan using evidence - based concepts, where applicable, is developed within 5 days of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
4. The attending physician is a psychiatrist or addictionologist and responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides an evaluation with documentation as indicated, no less than weekly.
5. The member and/or family member should be made aware of FDA approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
6. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
7. Licensed behavioral health practitioners supervise all treatment.
8. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
9. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
10. Multidisciplinary treatment program that occurs 5 days a week and provides 20 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms, New Directions does not count these activities in the total hours of treatment delivered.
11. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.

12. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
13. Family participation:
    a. For adults Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly.
    c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.
14. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.

Initial Authorization Request
SUDPHR

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 treatment each program day.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of twenty hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of twenty hours of treatment each week is required to safely and effectively treat the member's current condition.
5. The member is cognitively capable to actively engage in the recommended treatment plan.
6. Active substance use within one week of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
7. The member's recovery 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 (20 hours/week).
8. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 2 areas, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
9. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of

community resources or any other factors that would impact the overall treatment outcome and community tenure.

b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care

c. The member is at high risk for admission to a higher level of care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

10. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care **OR** the member has current morbidity from substance use disorder which requires medical evaluation and management.
11. There are acute psychiatric symptoms or cognitive deficits of moderate intensity that directly relate to a high risk of relapse and require concurrent mental health treatment at the PHP level of care **AND** these psychiatric services are provided in a timely manner at the appropriate intensity.

Continued Authorization Request(s)
SUDPHR

Must meet 1 through 10 and either 11, 12 or 13: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

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 for improvement in the severity of the current condition and behaviors that require a minimum of twenty hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, relapse prevention interventions, facilitates the development of recovery supports and other services to benefit the member in his/her recovery process.
7. The program supports and helps the member to develop, acquire and utilize new learned skills to achieve sobriety in a real-world environment. Examples include but are not limited to:
    a. Confirmed attendance at outside recovery support meetings such as 12 Step, SMART Recovery, etc.
    b. Developing a temporary sponsor in the AA community

c. Attending vocational training or education outside the treatment facility
d. Actively seeking paid work or a volunteer position
e. Regular interactions with family, friends, children and other identified supports
f. Developing adaptive sober behaviors in their place of permanent residence

8. The member is displaying increasing motivation, interest in and ability to actively engage in his/her substance use disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively building a relapse prevention plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
9. The member's treatment plan is centered on the alleviation of disabling substance use disorder symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. There are acute psychiatric symptoms or cognitive deficits of moderate intensity that require concurrent mental health treatment at the PHP level of care **AND** these psychiatric services are provided in a timely manner at the appropriate intensity.
12. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care **OR** the member has current morbidity from substance use disorder requiring medical evaluation and management.
13. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions that a member has an acute and imminent risk of decompensation are supported by confirmatory objective clinical evidence.

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.

Substance Use Disorder Intensive Outpatient Rehabilitation Criteria

Intensity of Service

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

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests upon admission and as clinically indicated.
3. After a multidisciplinary assessment, an individualized treatment plan using evidence - based concepts, where applicable, is developed within 5 days of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
4. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
5. The member and/or family member should be made aware of FDA approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
6. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
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. A multidisciplinary treatment program occurs 3 days per week and provides a minimum of 9 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms, New Directions does not count these activities in the total hours of treatment delivered.
9. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
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. Family participation:

a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy 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 at least weekly.
c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.

Initial Authorization Request
SUDIOR

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 treatment each program day.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of nine hours of treatment each week is required to safely and effectively treat the member's current condition.
5. The member is cognitively capable to actively engage in the recommended treatment plan.
6. Active substance use disorder behavior within two weeks of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.
7. The member's recovery environment and support systems are generally supportive of rehabilitation and the member can succeed in treatment with the intensity of current treatment services.
8. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 1 area, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
9. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes,

lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.

b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.

c. The member is at high risk for admission to a higher level of care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

10. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care **OR** the member has current morbidity from substance use disorder, which requires regular medical evaluation and management.
11. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care **AND** these services are provided at in a timely manner the appropriate intensity.

Continued Authorization Request(s)
SUDIOR

Must meet 1 – 10 and at least one of 11, 12 or 13: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

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 for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, relapse prevention interventions, facilitates the development of recovery supports and other services to benefit the member in his/her recovery process.
7. The program supports and helps the member to develop, acquire and utilize new learned skills to achieve sobriety in a real-world environment. Examples include but are not limited to:
    a. Confirmed attendance at outside recovery support meetings such as 12 Step, SMART Recovery, etc.
    b. Developing a temporary sponsor in the AA community
    c. Attending vocational training or education outside the treatment facility
    d. Actively seeking paid work or a volunteer position
    e. Regular interactions with family, friends, children and other identified supports

f. Developing adaptive sober behaviors in their place of permanent residence

8. The member is displaying increasing motivation, interest in, and ability to actively engage in his/her substance use disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively building a relapse prevention plan and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
9. The member's treatment plan is centered on the alleviation of disabling substance use disorder symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care **AND** these psychiatric services are provided in a timely manner at the appropriate intensity.
12. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions that a member has an acute and imminent risk of decompensation are supported by confirmatory objective clinical evidence.
13. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care **OR** the member has current 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.*

Substance Use Disorder Outpatient Rehabilitation Criteria	SUDOPR

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 member and/or family member should be made aware of FDA approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.
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. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan.
6. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 or other limitation.
7. Planning to transition to community resources is addressed in the treatment plan.

Initial Authorization Request
SUDOPR

Must meet 1 – 5 and either 6 or 7:

1. A DSM diagnosis of substance use disorder, which is the primary focus of rehabilitative treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, 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 care **or** the member has morbidity from substance use disorder requiring medical evaluation and management.

Continued Authorization Request(s)
SUDOPR

Must meet 1 – 6 and either 7 or 8:

1. A DSM diagnosis of substance use disorder, which is the primary focus of rehabilitative treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, 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 care, or the member has morbidity from substance use disorder requiring medical evaluation and management.

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 state agency that approves healthcare facility licensure.
2. There is documentation that 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 relevant lab tests (electrolytes, chemistry, CBC, thyroid and ECG) upon admission and as clinically indicated.
4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 24 hours of admission. The physician or physician extender provides daily 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical, psychiatric or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure .
6. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
7. There is documentation that the member is evaluated daily by a licensed behavioral health practitioner.
8. Mental health or medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. On-site registered nursing care available 24 hours a day 7 days a week with full capabilities for all appropriate interventions in medical and behavioral health and emergencies that occur on the unit.
10. 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.
11. Nutritional planning with target weight range and planned interventions by a registered dietitian is undertaken.
12. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs of the member identified on the treatment plan. In addition, the program is operated with licensed clinical staff who are trained and experienced in the treatment of eating disorders and under the direction of a certified eating disorder specialist.
13. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 24 hours of admission.
14. Family participation:

a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly or more often if clinically indicated.
c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request

EDI

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 for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Meets at least one criterion, 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
Serum glucose	<45 mg/dl	<45 mg/dl
Orthostatic changes BP AND pulse Supine to standing measured with 3-minute wait	systolic: > 20-point drop diastolic: >10-point drop pulse: > 20 bpm	systolic: > 20-point drop diastolic: >10-point drop 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 (bingeing, purging, laxative abuse, excessive exercise, etc.) that occur multiple times daily, have caused severe 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 Authorization Request(s)

EDI

Must meet all of the following: (N.B., criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, daily treatment. For members severely underweight (IBW < 85%), the expectation of weight gain of 2 pounds each week.
2. Family/support system coordination, as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
3. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
4. The treatment is not primarily social, interpersonal, domiciliary or respite care.
5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process .
7. The member is displaying increasing motivation, interest in and ability to actively engage in his/her eating disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, increasing ability to eat independently, actively developing discharge plans and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
8. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing

appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.

9. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.

Eating Disorder Residential 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 state agency that approves healthcare facility licensure.
2. There is documentation that the member's history and physical examination with medical clearance is completed 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 relevant lab tests (electrolytes, chemistry, CBC, thyroid and ECG) upon admission and as clinically indicated.
4. The attending physician is a psychiatrist and is responsible for diagnostic evaluation within 48 hours of admission. The physician or physician extender provides an evaluation a minimum of twice per week with documentation. The physician must be 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. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical, psychiatric or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
6. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
7. There is documentation that the member is evaluated daily by a licensed behavioral health practitioner.
8. On-site registered nursing care available 24 hours a day seven days a week with full capabilities for all appropriate interventions in medical and behavioral health and emergencies that occur on the unit.
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. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs of the member identified on the treatment plan. In addition, the program is operated with licensed clinical staff who are trained and experienced in the treatment of eating disorders and under the direction of a certified eating disorder specialist.
11. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by arrangement.
12. Nutritional planning with target weight range and planned interventions by a registered dietitian is undertaken.
13. 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.

14. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 72 hours of admission.
15. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly or more often if clinically indicated.
    c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request
EDR

Must meet 1 – 6 and either 7 or 8:

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 for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and daily 24-hour care is required to safely and effectively treat the member's current condition.
5. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 3 areas, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
6. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    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's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.

c. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.

d. The member is at high risk for admission to a higher level of care secondary to multiple recent previous inpatient treatments that resulted in unsuccessful stabilization in the community post-discharge.
Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

7. 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
Serum glucose	<45 mg/dl	<45 mg/dl
Orthostatic changes: BP AND pulse **Supine to standing measured with 3-minute wait**	systolic: > 20-point drop diastolic: >10-point drop pulse: > 20 bpm	systolic: > 20-point drop diastolic: >10-point drop 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

8. 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 (bingeing, purging, laxative abuse, excessive exercise, etc.) that occur multiple times daily, have caused severe 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 Authorization Request(s)
EDR

Must meet all of the following: (N.B., criteria #6 should only be used when the member seeks treatment outside of their home geographic area and #7 only if there are multiple recent admissions)

1. A DSM diagnosis found in the Feeding and Eating Disorder is the primary focus of active, daily treatment. For members severely underweight (IBW < 85%), there is an expectation of weight gain of 2 pounds each week.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require care 24 hours daily to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. 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.
5. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
6. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
7. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.
8. The member is displaying increasing motivation, interest in and ability to actively engage in his/her eating disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, increasing ability to eat independently, actively developing discharge plans and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
9. The member's treatment plan is centered on the alleviation of disabling eating disorder symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
10. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed mental health practitioner within seven days of discharge.
11. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.

12. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Eating Disorder Partial Hospitalization Criteria

Intensity of Service

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

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests (electrolytes, chemistry, CBC, thyroid and ECG) upon admission and as clinically indicated.
3. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides an 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 5 days of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical, psychiatric or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.
5. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
6. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
7. Licensed behavioral health practitioners supervise all treatment.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. A multidisciplinary treatment program occurs 5 days per week and provides 20 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. In addition, the program is operated with licensed clinical staff who are trained and experienced in the treatment of eating disorders and under the direction of a certified eating disorder specialist. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms, New Directions does not count these activities in the total hours of treatment delivered.
10. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery
11. Nutritional planning with targeted weight range and planned interventions with a registered dietitian is undertaken.
12. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.

13. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.
14. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly.
    c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request
EDPH

Must meet 1 -11 and either 12 or 13:

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 for improvement in the severity of the current condition and behaviors and this requires a minimum of twenty hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. 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.
5. The member needs supervision during and/or after meals to ensure adequate nutritional intake and prevent compensatory behavior.
6. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of twenty hours of treatment each week is required to safely and effectively treat the member's current condition.
7. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 2 areas, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
8. The member is cognitively capable to actively engage in the recommended treatment plan.
9. The member needs daily supervision during and/or after most meals to ensure adequate nutritional intake and prevent compensatory behavior.
10. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    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 eating disorder effectively, such that treatment at a lower level of care is unlikely to be successful.

b. The member's office based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.

c. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.

d. The member is at high risk for admission to a higher level of care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.
Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

11. If present, acute biomedical complications and/or psychiatric comorbidities receive active medical management as appropriate.
12. If the member is severely underweight there is documentation of being greater than 75% of IBW or a BMI greater than 15.
13. If compensatory behaviors (bingeing, purging, laxative abuse, excessive exercise, etc.) are present, these occur with significant frequency and have resulted in significant physiologic complications that resulted in medical treatment.

Continued Authorization Request(s)
EDPH

Must meet all of the following: (N.B., criteria #6 should only be used when the member seeks treatment outside of their home geographic area and #7 only if there are multiple recent admissions)

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 (IBW < 90%), the expectation of weight gain of 1 pound each week.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of twenty hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. 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.
5. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
6. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
7. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation,

readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.

8. The member is displaying increasing motivation, interest in and ability to actively engage in his/her eating disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, increasing ability to eat independently, actively developing discharge plans and other markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.
9. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
11. If present, biomedical complications and/or psychiatric comorbidities receive active medical management as appropriate.
12. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

Eating Disorder Intensive Outpatient Criteria

Intensity of Service

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

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. There is documentation of drug screens and relevant lab tests (electrolytes, chemistry, CBC, thyroid and ECG) upon admission and as clinically indicated.
3. There is documentation of evaluation by a psychiatrist within one week of admission and is available as medically indicated thereafter for evaluations.
4. After a multidisciplinary assessment, an individualized treatment plan using evidence - based concepts, where applicable, is developed within 5 days of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical, psychiatric or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure .
5. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.
6. There is documentation that the member is evaluated on each program day by a licensed behavioral health practitioner.
7. Licensed behavioral health practitioners supervise all treatment.
8. Mental health and medical services are available 24 hours per day, seven days per week, either on-site or off-site by referral.
9. A multidisciplinary treatment program occurs 3 days per week and provides a minimum of 9 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. In addition, the program is operated with licensed clinical staff who are trained and experienced in the treatment of eating disorders and under the direction of a certified eating disorder specialist. If the program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms New Directions does not count these activities in the total hours of treatment delivered.
10. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
11. Nutritional planning with targeted weight range and planned interventions with a registered dietitian is undertaken.
12. There is documentation of a safety plan including access for the member and/or family/support system to professional supports outside of program hours.
13. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.
14. Family participation:

a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 at least weekly.
c. Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

Initial Authorization Request
EDIO

Must meet 1-9 and either 10 or 11:

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active treatment each program day. For members markedly underweight, the expectation of weight gain of 1 pound each week.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. 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.
5. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of nine hours of treatment each week is required to safely and effectively treat the member's current condition.
6. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 1 area, including but not limited to:
    a. potential safety issues for either self or others
    b. primary support
    c. social/interpersonal
    d. occupational/educational
    e. health/medical compliance
7. The member is cognitively capable to actively engage in the recommended treatment plan.
8. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    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 eating disorder effectively, such that treatment at a lower level of care is unlikely to be successful.
    b. The member's office based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, concurrent substance use disorder, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.

c. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency, duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.

d. The member is at high risk for admission to a higher level of care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community-post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

9. The member needs supervision during and/or after meals to ensure adequate nutritional intake and prevent compensatory behavior.
10. If the member is severely underweight there is documentation of being greater than 80% of IBW or a BMI greater than 15.6.
11. If compensatory behaviors (bingeing, purging, laxative abuse, excessive exercise, etc.) are present, these occur with marked frequency.

Continued Authorization Request(s)
EDIO

Must meet all of the following: (N.B., criteria #6 should only be used when the member seeks treatment outside of their home geographic area and #8 only if there are multiple recent admissions)

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active daily treatment. For members markedly underweight (IBW < 90%), the expectation of weight gain of 1 pound each week.
2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure and support.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. 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.
5. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.
6. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.
7. The treatment plan is focused on the alleviation of eating disorder symptoms and precipitating psychosocial stressors that are interfering with the member's ability to transition to treatment at a less intensive level of care.
8. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, practicing new skills to facilitate the development of recovery and other supports to benefit the member in his/her recovery process.
9. The member is displaying increasing motivation, interest in and ability to actively engage in his/her eating disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, increasing ability to eat independently, actively developing discharge plans and other markers of treatment

engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.

10. The member's treatment plan is centered on the alleviation of disabling symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.
11. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.
12. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms.

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. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
6. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 or other limitation.

Initial Authorization Request

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 for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, 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 Authorization Request(s)

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 for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, 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.

Psychological and Neuropsychological Testing Criteria	PNT

Intensity of Service

Must meet 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

PNT

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.

	ECTI
Electroconvulsive Therapy (ECT): Inpatient Criteria	

Intensity of Service

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

1. Meets Intensity of Service requirements 1 – 9 of the Psychiatric Acute Inpatient Criteria.
2. The primary attending physician is a psychiatrist, trained and credentialed to administer ECT. The attending is responsible for diagnostic evaluation and provides face -to-face services with documentation.
3. Meets all state laws and regulations regarding the practice of ECT.
4. 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.

Initial Authorization Request

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 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 at least one criteria from 6, 7, 8, 9 or 10 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 Authorization Request(s)

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 Disorder: depressed, mixed, manic
   c. Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
   d. Catatonia

e. Neuroleptic Malignant Syndrome

2. Meets all Continued Authorization Request(s) 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.

Electroconvulsive Therapy (ECT): Outpatient Criteria

ECTOP

Intensity of Service

All of the following:

1. If required, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.
2. The primary attending physician is a psychiatrist, trained and credentialed to administer ECT. 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.

Initial Authorization Request

ECTOP

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 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 Authorization Request(s)
ECTOP

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 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.

OBS

23-Hour Observation Criteria

Intensity of Service

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

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 within 23 hours of the entrance to the observation bed.
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.

Initial Authorization Request

OBS

Must meet 1 - 2 and one of either 3, 4, 5 or 6:

1. A DSM diagnosis is the primary focus of active treatment.
2. There is a 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.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. Emerging imminent risk of significant self-harm due to one of the following:
    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
5. Emerging imminent risk of significant harm to others due to one of the following:
    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
6. Acute intoxication with significant medical, emotional or behavioral disturbance requiring 24-hour medical management and intervention.
7. 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.

Crisis Intervention Services Criteria	CIS

Intensity of Service

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

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 needs 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.

Initial Authorization Request

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 needs a brief hiatus from caregiving 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.

Community Case Management Criteria

Intensity of Service

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

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: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy. 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 or other limitation.

Initial Authorization Request

CCM

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 treatment at this level of care.
3. The treatment is not primarily social, interpersonal, domiciliary or respite care.
4. The member meets Initial Authorization Request 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 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, 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.

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