Presbyterian Health Plan
Presbyterian Insurance Company, Inc.
Behavioral Health
Level of Care Guidelines

INTRODUCTION

Clinical criteria are developed to assist clinicians in assessing the medical necessity and appropriateness of level of care placement. This document is intended as a guideline to assist the clinicians working in behavioral health at Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian). It incorporates the principles of the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and the American Society of Addiction Medicine, as well as national and state mental health care standards and regulations. These criteria are designed to facilitate communication between the Presbyterian Behavioral Health Department and Presbyterian Behavioral Health Practitioners and Providers.

Psychiatric / mental health and substance abuse / dependency treatment authorized by Presbyterian Behavioral Health, is designed to be medically necessary, short-term, brief therapy for crisis intervention. ***These criteria will assist practitioners and providers in effective treatment planning and in providing improved care, and are intended as a guideline to evaluate medical necessity. While providing a framework for decision making, clinical judgment is an important adjunct to these criteria***

Many members with a chronic and persistent mental illness are in treatment with Presbyterian clinicians. Treatment for these patients is directed toward alleviating acute exacerbation of severe signs and symptoms and/or behaviors with a DSM-IV diagnosis or diagnoses being the basis for the signs/symptoms and/or behaviors. ***Please note that these criteria may not meet <u>all</u> the needs of the persistently chronically mentally ill who may require additional social supports, rehabilitation, and intensive care that are not reflected in this document. In addition, not all services are covered benefits under the various Presbyterian health care plans.***

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NUMBER 1
ACUTE INPATIENT HOSPITALIZATION

I. DEFINITION OF SERVICE:

Acute inpatient psychiatric treatment is a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for urgent or emergent behavioral health problems and is for stabilization of these problems. Acute inpatient service is provided specifically for those members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled or significantly impaired activities of daily living. This level of care involves the highest level of skilled psychiatric and substance abuse services. This service is rendered in a licensed freestanding psychiatric hospital or the psychiatric unit of a general hospital. The care must be provided under the direction of an attending psychiatrist who has performed a face-to-face interview of the member prior to or within 24 hours of admission. There is daily active treatment under the supervision of a psychiatrist with daily patient contact by a psychiatrist. The care involves an individualized treatment plan that addresses specific symptoms and has specific goals and objectives, and that receives regular review and revision. A discharge plan should be formulated that is directly linked to the behaviors or symptoms that resulted in admission, and that receives regular review including evaluation of post-hospital needs.

This level of care should not be authorized solely on a convenience basis and must not substitute the need for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as housing. This level of care is available for all age ranges, but admission should be to a unit that is age appropriate. For school age children and youth, academic schooling funded through the local school system or by the facility is expected.

II. ADMISSION CRITERIA (MEETS A AND B, AND C OR D OR E OR F OR G OR H):

A. The member has a DSM-IV or ICD-9-CM diagnosed psychiatric condition that requires, and is likely to benefit from, therapeutic intervention.
B. Treatment cannot safely be administered in a less restrictive level of care.
C. There is an indication of actual or potential danger to self as and these impulses cannot be controlled outside of a 24-hour treatment setting.

Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.

D. There is an indication of actual or potential imminent danger to others that cannot be controlled outside of a 24-hour treatment setting. An example of an indication includes a current threat and means to kill or injure someone.
E. There is disordered or bizarre thinking, psychomotor agitation or retardation, loss of impulse control or impairment in judgment leading to behaviors that place the individual or others in imminent danger due to an inability to meet basic personal needs and this cannot be controlled outside of a 24-hour treatment setting.
F. There is a co-existing medical illness that complicates the psychiatric illness or treatment and that poses a high risk for the member, and this cannot be managed outside of a 24-hour treatment setting.
G. Weight loss that is 15% below ideal weight, or failure to make expected weight gains during a period of growth, along with medical complications as a result of the eating disorder, life threatening medical complications, pregnancy or severe concurrent drug or alcohol use.
H. Failure of treatment at a less restrictive level.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria.
B. An individualized treatment plan that addresses the member's specific needs has been developed, implemented and updated, with the member or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
C. An individualized discharge plan with specific realistic, objective, and measurable discharge criteria including plans for appropriate follow-up care has been developed. A timeline for expected implementation and completion is in place but discharge criteria have not been met.
D. The member is involved in the treatment process or active efforts are being made to involve the member in treatment.
E. Progress towards discharge goals is being made as evidenced by compliance with treatment and/or measurable reduction in symptoms.

IV. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her individualized discharge criteria.
B. The member can be safely treated at a less intensive level of care.
C. An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.

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NUMBER 2
OBSERVATION STAY

I. DEFINITION OF SERVICE:

A 23-hour observation stay occurs in a secure, medically staffed, psychiatrically supervised facility. This level of care, like inpatient hospitalization, involves the highest level of psychiatric and substance abuse services. This service can be rendered in a licensed freestanding psychiatric hospital or the psychiatric unit of a general hospital, or in the emergency department of a licensed hospital. The care must be provided under the direction of an attending physician who has performed a face-to-face evaluation of the member. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services. A 23-hour observation stay provides an opportunity to evaluate members whose needed level of care is not readily apparent. In addition, it may be used to stabilize a member in crisis when it is anticipated that the member's symptoms will resolve in less than 24 hours.

This level of care may be considered when support systems and/or a previously developed crisis plan have not sufficiently succeeded in stabilizing the member and the likelihood for further deterioration is high.

This level of care is available for all age ranges.

II. ADMISSION CRITERIA (MEETS A AND B, AND C OR D OR E):

A. The member has a DSM-IV or ICD-9-CM diagnosed psychiatric condition that requires evaluation and is likely to benefit from therapeutic intervention in less than 24 hours.
B. The member cannot be evaluated in a less restrictive level of care.
C. The member is expressing suicidal ideation or is expressing threats of harm to others that must continue to be evaluated for severity and lethality.
D. The member has acted in disruptive, dangerous, or bizarre ways that require further immediate observation and evaluation. An evaluation of the etiology of such behaviors is needed, especially if suspected to be chemically or organically induced.
E. The member is presenting with significant disturbances of emotions or thought processes that interfere with his/her judgment or behavior, which could seriously endanger the member if not evaluated and stabilized on an emergency basis.

III. DISCHARGE CRITERIA (MEETS BOTH):

A. The member no longer meets admission criteria.
B. An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.

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NUMBER 3
PARTIAL HOSPITALIZATION

I. DEFINITION OF SERVICE:

Partial hospitalization is an intensive, structured and medically staffed, psychiatrically supervised treatment program intended for stabilization of acute psychiatric symptoms. The services are essentially of the same nature and intensity (including medical and nursing) as would be provided in an inpatient setting except that the member is in the program less than 24 hours a day. Partial hospitalization is designed for members with serious disorders or disturbances of community functioning that require an intensive, ambulatory, and active treatment program. The member can be maintained safely in the community but requires close monitoring. Support systems should be available and willing to assist the member with participation in treatment whenever possible. Partial hospitalization offers therapeutically intensive, multi-modal structured clinical services within a stable therapeutic milieu setting under the direction of a psychiatrist who has regular (2 or more times a week) contact with the patient. An individualized treatment plan is developed and reviewed on a regular basis. Partial hospitalization programs may vary considerably depending upon the age and severity of illness of the members for whom the program is structured.

This level of care is available for all age ranges, but admission should be to a program that is age appropriate. For school age members, elementary and secondary schooling funded through the local school system or by the facility is expected.

This level of care should not be confused with psychosocial rehabilitation or day treatment programs where the focus is on long-term social rehabilitation and maintenance of members with chronic and disabling mental illness.

II. ADMISSION CRITERIA (MEETS ALL):

A. The member has a DSM-IV or ICD-9-CM diagnosed psychiatric condition that requires, and is likely to benefit from, therapeutic intervention.
B. The member cannot be safely treated in a less intensive or structured setting.
C. The member exhibits acute disabling psychiatric symptoms of sufficient severity to bring about a significant impairment in day to day social, vocational, and/or educational functioning.
D. The member is able to exhibit adequate control over behavior so that he or she is not an immediate danger to self or others. The member or member's

support system is able and willing to access emergency services when necessary.

E. The member has the capacity for active participation in all phases of the treatment program, and support systems are adequate to assist the member to remain in the community.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria.
B. An individualized treatment plan that address the member's specific needs has been developed, implemented, and updated, with the member or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
C. An individualized discharge plan with specific realistic, objective, and measurable discharge criteria including plans for appropriate follow-up care has been developed. A timeline for expected implementation and completion is in place but discharge criteria have not been met.
D. The treatment goals are realistically achievable.
E. The member is involved in the treatment process or active efforts are being made to involve the member in treatment.
F. Progress towards discharge goals is being made as evidenced by compliance with treatment and/or measurable reduction in symptoms.

II. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her individualized discharge criteria.
B. The member can be safely treated at a less intensive level of care.
C. A discharge plan with appropriate, realistic, and timely follow-up care is in place.

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NUMBER 4
RESIDENTIAL TREATMENT SERVICES

I. DEFINITION OF SERVICE:

Residential treatment services (RTS) are provided to members under the age of 18 years who require 24-hour intervention and supervision in a safe therapeutic environment. RTS is a non-hospital 24-hour a day / 7 day a week facility based level of care that provides members suffering from significant psychological or behavioral disorders with residential treatment. Facilities provide diagnostic and therapeutic services that cannot be provided in a community setting. The services are provided with the involvement of a psychiatrist who performs observation and a face-to-face assessment on at least a weekly basis. The services are provided in accordance with an individualized treatment plan that is frequently reviewed and updated based on the member's clinical status. Regular family therapy is a key element of treatment and strongly encouraged unless clinically contraindicated. Discharge planning should begin at admission, including plans for reintegration into the home, school, and identification of community resources. If discharge to a home/family is not an option, alternative placement must be rapidly identified and there must be frequent documentation of active efforts to secure such placement.

This level of care should not be authorized solely on a convenience basis, is not for maintenance of behaviors and must not substitute for the need for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as housing. Academic schooling funded through the local school system or by the facility is expected.

Not all members have RTS as a covered benefit. Please refer to the individual plan and Group Subscriber Agreement for more information.

II. ADMISSION CRITERIA (MEETS ALL):

A. The member has a DSM-IV or ICD-9-CM diagnosed psychiatric condition that requires, and is likely to benefit from, therapeutic intervention.
B. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety of the member or others is at risk. These problems require a supervised, structured, and 24-hour a day therapeutic milieu in a residential setting.

C. Less restrictive or intensive levels of treatment have been tried or are not appropriate to meet the member's needs.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria.
B. An individualized treatment plan that addresses the member's specific needs has been developed, implemented, and updated, with the member or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
C. An individualized discharge plan with specific realistic, objective, and measurable discharge criteria including plans for appropriate follow-up care has been developed. A timeline for expected implementation and completion is in place but discharge criteria have not been met.
D. The member is participating in treatment or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
E. The parent, guardian or custodian is participating in the treatment and discharge planning, or persistent efforts are being made and documented to involve them (unless it is clinically indicated otherwise).
F. Progress towards discharge goals is being made as evidenced by compliance with treatment or measurable reduction in symptoms.

IV. DISCHARGE CRITERIA (MEETS A OR B, and C AND D):

A. The member has met his/her individualized discharge criteria.
B. The member has not benefited from RTS despite documented efforts to engage the member.
C. The member can be safely treated at a less intensive level of care.
D. A discharge plan with appropriate, realistic, and timely follow-up care is in place.

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NUMBER 5
INTENSIVE OUTPATIENT PROGRAMS

I. DEFINITION OF SERVICE:

Intensive Outpatient Programs provide intense, comprehensive multi-modal outpatient treatment for members with emotional or behavioral symptoms that are severe enough to require frequent treatment in order to improve, stabilize, or prevent further deterioration in the member's functioning. In contrast to day treatment, this level of care is appropriate for members who can maintain family, student, or work responsibilities in the community with this intensive treatment. Treatment usually consists of structured interventions on an outpatient basis at least three days a week for three hours per day or more. Services include individual, group, family, or multi-family group therapies. A comprehensive multi-modal individualized treatment plan is developed for the member with the goal of stabilizing the member's behavior to allow for further treatment at a lower level of care. If necessary, support systems are available to assist the member with participation in treatment.

This level of care is available for all ages but admission should be to a program that is age appropriate.

II. ADMISSION CRITERIA (MEETS BOTH):

A. The member has a DSM-IV or ICD-9-CM diagnosed psychiatric condition that requires, and is likely to benefit from, therapeutic intervention.
B. The member is able to function in social, vocational, or educational settings; however, symptoms are sufficiently significant to require more intensive intervention than regular outpatient services.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria for psychiatric intensive outpatient program.
B. An individualized treatment plan that addresses the member's specific needs has been developed, with the member's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.
C. An individualized discharge plan with specific realistic, objective, and measurable discharge criteria including plans for appropriate follow-up care has been developed. A timeline for expected implementation and completion is in place but discharge criteria have not been met.

D. The member is participating in treatment or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
E. Progress towards discharge goals is being made as evidenced by compliance with treatment or measurable reduction in symptoms.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.
B. The member has not benefited from the Intensive Outpatient Program despite documented efforts to engage the member.
C. The member can be safely treated at a less intensive level of care.
D. A discharge plan with appropriate, realistic, and timely follow-up care is in place.

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NUMBER 6
OUTPATIENT SERVICES

I. DEFINITION OF SERVICE:

Outpatient behavioral health services may include individual, couple, family, group, medication management and monitoring, evaluation, testing and therapy required to alleviate acute symptom, provide emotional or behavioral stabilization, or prevent the need for treatment in a higher level of care. Outpatient services are generally provided in an office, clinic or home environment, although they may rarely also be provided in a school or vocational setting. The intensity of treatment is highly variable and depends upon the member's diagnosis and presenting symptoms. While various combinations of modalities may be employed, the more extensive services of an Intensive Outpatient Program or partial hospitalization program are not required.

The outpatient diagnostic process serves the purpose of clarifying symptoms, issues, and level(s) of impairment as well as developing a treatment approach. The outpatient provider utilizes the member's strengths, coping strategies, and available community resources and support systems. Treatment interventions are expected to be solution focused and highly interactive. There is an expectation that the therapist and member will collaborate to establish mutually agreed upon treatment objectives, and that when objectives are met, the treatment will end.

II. ADMISSION CRITERIA (MEETS ALL):

A. The member has a DSM-IV or ICD-9-CM diagnosed psychiatric condition that requires, and is likely to benefit from, therapeutic intervention.
B. The member presents with significant impairment of function in at least one life area.
C. The member is motivated for or amenable to treatment by a behavioral health professional.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria for outpatient services.
B. An individualized treatment plan that addresses the member's specific needs has been developed, implemented and updated, with the member or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.

C. An individualized discharge plan with specific realistic, objective, and measurable discharge criteria including plans for appropriate follow-up care has been developed. A timeline for expected implementation and completion is in place but discharge criteria have not been met.
D. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.
E. Progress towards discharge goals is being made as evidenced by compliance with treatment or measurable reduction in symptoms.
F. All available outside support systems and resources have been identified and are utilized by the patient.

IV. DISCHARGE CRITERIA (MEETS A OR B):

A. The member has met his/her individualized discharge criteria
B. The member has not benefited from outpatient services despite documented persistent efforts to engage the member.

NUMBER 7
SUBSTANCE ABUSE SERVICES

For substance abuse services, Presbyterian Behavioral Health will utilize the American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC-2R). Please note that not all members have substance abuse services as a covered benefit. In addition, for those members with substance abuse benefits, some levels of substance abuse care may not be covered. Refer to the Individual Plan, Group Subscriber Agreement, Summary Plan Description, or Evidence of Coverage for more information.

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NUMBER 8
ELECTROCONVULSIVE THERAPY

I. DEFINITION OF SERVICE:

Electroconvulsive therapy (ECT) is a beneficial treatment for certain disorders and is usually administered in an inpatient or outpatient facility that provides both psychiatric and anesthesiology services. ECT should be considered in cases of severe or treatment resistant depression, psychotic disorders, or prolonged or severe mania. In addition, ECT may be indicated when there is a history of a positive response to ECT, a contraindication to standard psychotropic medication treatments, or when there is an urgent need for response, such as severe suicidality or food refusal leading to nutritional compromise. A valid consent must be obtained for ECT; if the member is not competent to refuse or consent to the procedure, then a treatment guardian should be obtained. The person giving consent should be informed of the risks and benefits of ECT along with alternative treatments considered, and the record should document that the member or guardian clearly understands these elements of the consent.

These criteria will be used to authorize the procedure of ECT. Authorization for this procedure does not imply authorization for a particular level of care or for anesthesia services.

II. CRITERIA FOR APPROVAL (MEETS ALL):

A. Medical necessity has been met and the member has a DSM IV or ICD-9-CM diagnosed psychiatric condition that requires, and is likely to benefit from, therapeutic intervention.
B. A second opinion from a psychiatrist confirms that ECT is an appropriate treatment for the member.
C. A medical evaluation indicates no contraindication for ECT.
D. Informed consent for ECT has been obtained and documented in the treatment record.
E. The member has treatment resistant depression or psychotic disorder, is experiencing a severe or prolonged manic episode unresponsive to usual treatments, cannot tolerate usual psychotropic medications, exhibits food refusal leading to nutritional compromise, or is experiencing such intense suicidal ideation that there is an urgent need for response.

III. CRITERIA FOR MAINTENANCE ELECTROCONVULSIVE THERAPY (MEETS ALL)

A. The member meets the criteria for approval for ECT as outlined above, received ECT, and had a positive response.
B. Other treatment options are not viable for the member.
C. A second opinion from a psychiatrist is obtained every six months documenting the need for maintenance ECT.