Autism Spectrum Disorder and Intensive Behavior Therapy

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Product:
2001 Generic UnitedHealthcare COC/SPD
2007 Generic UnitedHealthcare COC/SPD
2009 Generic UnitedHealthcare COC/SPD
2011 Generic UnitedHealthcare COC/SPD

Related Coverage Determination Guidelines:
Experimental, Investigational or Unproven Services
Home-Based Outpatient Treatment
Psychological and Neuropsychological Testing
School-Based Services

Related Medical Policies:
American Academy of Child and Adolescent Psychiatry, Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorder, 2014
Behavior Analyst Certification Board: Health Plan Guidelines, 2014
Level of Care Guidelines, 2016

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California (“Optum-CA”).

When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based.
In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently, or there is otherwise a conflict between this document and the COC/SPD, the enrollee’s specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.

While this Coverage Determination Guideline does reflect Optum’s understanding of current best practices in care, it does not constitute medical advice.

Key Points

- According to the DSM, the essential features of Autism Spectrum Disorder (ASD) are persistent impairment in reciprocal social communication and social interaction, and restrictive, repetitive patterns of behavior, interests or activities. Symptoms of ASD are present from childhood and impair everyday functioning. (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), 2013).

- Intensive Behavior Therapy (IBT) is an umbrella term for a variety of outpatient behavioral/educational interventions that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with ASDs. The most common IBTs are Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

- The course of IBT is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.

- Optum considers IBT to be unproven*, however Optum covers IBT for the treatment of Autism Spectrum Disorder when state-mandated or when these treatments are specifically included in a member’s benefit plan (Certificate of Coverage, 2007, 2009 & 2011). Use of this guideline may be extended to other conditions or age groups when benefits are mandated by regulation or customer contract.

- Pre-notification is required for inpatient, residential treatment center, partial hospital/day treatment programs, intensive outpatient, and home-based outpatient treatment.

- Services should be consistent with evidence-based interventions and clinical best practices as described, and should be of sufficient intensity to address the member’s needs (Certificate of Coverage, 2007, 2009 & 2011).

PART I: BENEFITS

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

Intensive Behavior Therapy such as Applied Behavioral Analysis is considered experimental, investigational or unproven, and excluded when not mandated by a superseding State requirement or included in the Certificate of Coverage as an expanded benefit. In these instances evidence-based treatments for Autism Spectrum Disorder may be covered.

Benefits
Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

**Covered Services**

**Covered Health Service(s) – 2001**

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions.

**Covered Health Service(s) – 2007, 2009 and 2011**

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards” shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
• "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

**Pre-Service Notification**

Admissions to an inpatient, residential treatment center, intensive outpatient home-based outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including Emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

**Limitations and Exclusions**

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee’s benefit document, or is otherwise defined differently, it is the terms of the enrollee’s benefit document that prevails.

**Inconsistent or Inappropriate Services or Supplies – 2001, 2007, 2009 & 2011**

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

• Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

• Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.

• Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practice guidelines as modified from time to time.

• Not clinically appropriate for the member’s Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

**Additional Information**

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all inclusive list):
• Services that deviate from the indications for coverage summarized earlier in this document.

• Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program without evidence-based treatment of acute symptoms.

• Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program for the sole purpose of awaiting placement in a long-term facility.

• Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program that does not provide adequate nursing care and monitoring, or physician coverage.

Please refer to the enrollee’s benefit document for ASO plans with benefit language other than the generic benefit document language.

The following are examples of inconsistent or inappropriate services for the treatment of Autism spectrum disorder (not an all-inclusive list):

• Services that deviate from the indications for coverage summarized in this guideline.

• Autism Spectrum Disorder services delivered by a provider not properly trained, licensed and credentialed to provide services as indicated in this guideline.

• School-Based Services or services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA).

• Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

• Intensive Behavioral Therapies such as Applied Behavior Analysis, The Denver Model and Relationship Development Intervention for Autism Spectrum Disorder when not supported by a separately purchased benefit plan or State requirement.

PART II: CLINICAL BEST PRACTICES

Evaluation and Treatment Planning

1. The initial evaluation (Optum Level of Care Guidelines, 2015):

   1.1. Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services (i.e., the “why now” factors).

   1.2. Focuses on the member’s specific needs.

   1.3. Identifies the member’s goals and expectations.
1.4. Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:

1.5.1. The member’s chief complaint;
1.5.2. The history of the presenting illness;
1.5.3. The “why now” factors leading to the request for service;
1.5.4. The member’s mental status;
1.5.5. The member’s current level of functioning;
1.5.6. Urgent needs including those related to the risk of harm to self, others, or property;
1.5.7. The member’s use of alcohol, tobacco, or drugs;
1.5.8. Co-occurring behavioral health and physical conditions;
1.5.9. The history of behavioral health services;
1.5.10. The history of trauma;
1.5.11. The member’s medical history and current physical health status;
1.5.12. The member’s developmental history;
1.5.13. Pertinent current and historical life information including the member’s:
   1.5.13.1. Age;
   1.5.13.2. Gender, sexual orientation;
   1.5.13.3. Culture;
   1.5.13.4. Spiritual beliefs;
   1.5.13.5. Educational history;
   1.5.13.6. Employment history;
   1.5.13.7. Living situation;
   1.5.13.8. Legal involvement;
   1.5.13.9. Family history;
   1.5.13.10. Relationships with family, friends and others;
1.5.14. The member’s strengths;
1.5.15. Barriers to care;
1.5.16. The member’s instructions for treatment, or appointment of a representative to make decisions about treatment;
1.5.17. The member’s broader recovery, resiliency and wellbeing goals.

2. **The Autism evaluation considers:**

2.1. The member’s baseline level of functioning and how the member will benefit from highly structured IBT interventions (American Academy of Child and Adolescent Psychiatry, Autism Practice Parameter (AACAP, 2014).

2.2. A structured diagnostic interview such as the Autism Diagnostic Interview-Revised (ADI-R) used to evaluate (AACAP, 2014):

   - 2.2.1. Family functioning;
   - 2.2.2. Communication skills;
   - 2.2.3. Motor skills;
   - 2.2.4. Cognitive functioning; and
   - 2.2.5. Adaptive functioning.

2.3. The collection of historical information to include (American Academy of Pediatrics, Autism (AAP, 2007); AACAP, 2014; DSM-5, 2013):

   - 2.3.1. Autism symptoms to include social relatedness, core ASD symptoms and repetitive or unusual behaviors.
   - 2.3.2. Pregnancy, neonatal, and developmental history;
   - 2.3.3. Previous ASD screening results, if applicable;
   - 2.3.4. Medical history to include seizures, sensory deficits, hearing or visual impairments, or other medical and behavioral conditions;
   - 2.3.5. History of observations from multiple sources including family members, teachers, other providers and child-care workers, incorporating the use of standardized tools when possible;
   - 2.3.6. History of any developmental regression;
   - 2.3.7. History of treatment interventions and response to treatment;
   - 2.3.8. History of behavior patterns and functional skills.

2.4. Direct observations to include (DSM-5, 2013):

   - 2.4.1. The member in multiple settings, being attentive to environmental factors;
   - 2.4.2. The member’s symptoms specific to the areas of social interaction, communication, play and language;
   - 2.4.3. Aggression, self-injury or stereotypic behavior or movement.
2.4.4. A functional behavior assessment and skill assessment may be needed if the member is displaying self-injurious, or other aggressive behaviors.

2.5. The use of standardized tools such as (AACAP, 2014):

2.5.1. Autism Behavior Checklist (ABC);
2.5.2. Autism Diagnostic Observation Schedule (ADOS-2);
2.5.3. Autism Diagnostic Interview (ADI);
2.5.4. Childhood Autism Rating Scale (CARS);
2.5.5. Checklist for Autism in Toddlers (M-CHAT);

2.6. A differential diagnosis from other medical, neurodevelopmental and behavioral conditions, including the identification of comorbidities is completed (AAP, 2007; AACAP, 2014; DSM-5, 2013).

2.7. The provider uses the findings of the evaluation to assign the appropriate DSM/ICD diagnosis(es) (Optum Level of Care Guidelines, 2015).

3. Treatment Planning

3.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses (Optum Level of Care Guidelines, 2015):

3.1.1. The short- and long-term goals of treatment;
3.1.2. The type, amount, frequency and duration of treatment;
3.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;
3.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;
3.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.

3.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.
3.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.

3.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.

3.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.

3.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.

3.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.

3.5.2. When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.

3.6. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

4. IBT Treatment Planning

4.1. As clinically indicated, the treatment plan addresses how learned skills that can be generalized to the home.

4.2. The treatment plan is in sync with the member’s Individual Family Service Plan (IFSP)/ Individualized Education Plan (IEP).

4.3. If the member is an older child or adolescent, the treatment plan reflects a plan to transition the member into adult services.

4.4. All components of the member’s care is tracked and updated through the duration of services to include:

4.4.1. Treatment planning a minimum of 1 hour per month up to 8 hours per month (not to exceed 1 hour for every 10 hours of direct service).

4.4.2. A separate transition plan is needed for children who are moving into or out of the school system.
4.5. Updated treatment plans for members with an ASD include:

4.5.1. Changes in treatment hours and level of care.

4.5.2. The member’s progress, new goals, and visual representations of skills and behavioral gains.

4.5.3. A transition plan detailing how the member will be transitioned out of services or to a lower level of care.

4.5.4. If the member is an older child or adolescent the treatment plan addresses the plan to transition members out of ASD treatment into adult care.

Interventions

1. IBT Interventions

1.1. Once an ASD diagnosis has been established (Behavior Analyst Certification Board, 2014):

1.1.1. A functional assessment is used to identify behaviors for reduction, and a skills-based assessment to determine skills to be increased should be completed. Targets include areas such as the following:

1.1.1.1. Communication skills;

1.1.1.2. Language skills;

1.1.1.3. Social interaction skills;

1.1.1.4. Self-injurious, violent, destructive or other maladaptive behavior.

1.2. A credentialed network provider with IBT expertise is identified to provide treatment. Examples include (Behavior Analyst Certification Board, 2014):

1.2.1. A Masters or Doctoral-level provider that is a Board Certified Behavior Analyst (BCBA);

1.2.2. A licensed behavioral health clinician who has attested to having sufficient expertise and has been credentialed to provide ABA services;

1.2.3. A Board Certified Assistant Behavior Analyst (BCaBA) or non-licensed individual under the direct supervision of a BCBA or licensed behavioral health clinician who takes responsibility for the member’s care that does either of the following:

1.2.3.1. Assist in the initial or concurrent assessment of the member’s deficits or adaptive behaviors;
1.2.3.2. Implement a treatment plan that has been developed by a BCBA or licensed behavioral health clinician.

1.2.3.3. Paraprofessional interventions must be directly supervised with the member present at least 1 hour per month, up to 8 hours per month, not to exceed 1 hour for every 10 hours of direct care provided.

1.3. The IBT interventions seek to address all of the following:

   1.3.1. Mitigate the core features of ASD such as impairment in social reciprocity, deficits in communication, and restricted or repetitive behaviors.

   1.3.2. Include parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home.

   1.3.3. Include psychotherapy for higher functioning members.

   1.3.4. Target specific deficits related to imitation, attention, motivation, compliance and initiation of interaction, and the specific adaptive behaviors that are to be incrementally taught and positively reinforced.

   1.3.5. Tie to objective and quantifiable treatment goals that have projected timeframes for completion.

   1.3.6. Have an appropriate level of frequency and intensity driven by:

      1.3.6.1. Changes in the targeted behavior(s);

      1.3.6.2. The demonstration and maintenance of management skills by the parents/guardians;

      1.3.6.3. Whether specific issues are being treated in a less intensive group format (e.g., social skills groups);

      1.3.6.4. The member’s ability to participate in IBT given attendance at school, daycare or other treatment settings; and

      1.3.6.5. The impact of co-occurring behavioral or medical conditions on skill attainment.

1.4. Services are intensive and may be provided daily, but ordinarily will not exceed 8 hours per day or 40 hours per week inclusive of other interventions. These hours of service also take into account other non-behavioral services such as school, speech and occupational therapies, generally covered by other entities.
1.5. Outcome-oriented interventions targeting specific baseline behaviors are implemented. Examples include:

1.5.1. Applied Behavior Analysis (ABA) and specific ABA techniques may be delivered in a variety of settings (e.g., home, classroom, community). These interventions are designed to reduce problem behavior and teach functional alternative behaviors and skills through behavior change. These following methods may be used individually or in combination (BACB, 2014):

1.5.1.1. Discrete Trial Training (DTT) methods establish learning readiness by teaching foundation skills such as attention, compliance, imitation, and discrimination learning, as well as many other skills.

1.5.1.2. Joint Attention involves teaching a child to respond to the nonverbal social bids of others or to initiate joint attention interactions. Examples include pointing to objects, showing items/activities to another person, and following eye gaze.

1.5.1.3. Natural Environmental Training involves using primarily child-directed interactions to teach functional skills in the natural environment. These interventions often involve providing a stimulating environment, modeling how to play, encouraging conversation, providing choices and direct/natural reinforcers, and rewarding reasonable attempts.

1.5.1.4. Pivotal Response Training focuses on targeting "pivotal" behavioral areas such as motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues. PRT focuses on parent involvement in the intervention delivery, and on intervention in the natural environment such as homes and schools with the goal of producing naturalized behavioral improvements.

1.5.2. Developmental/Relationship Interventions such as the Denver Model and RDI involve a combination of procedures that are based on developmental theory and emphasis is on the importance of building social relationships. These treatments may be delivered in a variety of settings (e.g., home, classroom, community) (Optum Technology Assessment, 2011).
1.5.2.1. The Early Start Denver Model (ESDM) is a set of procedures based on developmental and behavioral theory and emphasizes the importance of reducing the severity of autism symptoms and accelerate children’s developmental rates in all domains, but particularly cognitive, social-emotional, and language domains in infants/toddlers ages 12 months to 3 years old (Optum Technology Assessment, 2011).

1.5.2.2. The Denver Model is based on remediating key deficits in imitation, emotion sharing, theory of mind, and social perception by using play, interpersonal relationships and activities to foster thought and communication. It includes services in the home and school environments for children, ages 3-5 years old.

1.5.3. Relationship Development Interventions (RDI) are cognitive-developmental intervention strategies for parents to utilize with young children to address perceptual, cognitive, and emotional difficulties (Optum Technology Assessment, 2011).

1.5.3.1. RDI focuses on activities that elicit interactive behaviors with the goal of engaging the child in a social relationship in order to discover the value of positive interpersonal activity and therefore becoming more motivated to learn the skills necessary to sustain these relationships (Optum Technology Assessment, 2011).

1.5.3.2. Relationship Development Intervention, as a Developmental Treatment for ASD, does not meet the criteria for a Proven or Emerging treatment and the limited evidence currently suggests RDI as an Unproven Technology (Optum Technology Assessment, 2011).

2. Other Interventions

2.1. Cognitive Behavioral (CBT) Interventions and Social Skills Training interventions have shown efficacy in targeting and anxiety, response to social interactions with other children and adults, initiating social behavior, minimizing stereotyped behavior while using a flexible and varied repertoire of responses, and self-managing new and established skills (AACAP, 2014).
2.1.1. CBT interventions target comorbid anxiety, response to social interactions with other children and adults, initiating social behavior, minimizing stereotyped behavior while using a flexible and varied repertoire of responses, and self-managing new and established skills (AACAP, 2014).

2.2. Medications can be used to target maladaptive behaviors or common co-occurring behavioral health conditions (AACAP, 2013). Medication best practices for the co-occurring condition should be followed. Considerations include:

2.2.1. Lower initial doses and incremental increases are essential when treating members with ASD (AAP, 2007).

2.2.2. Documentation of baseline symptoms and changes as a result of medication is needed to determine response and/or improvement of targeted behaviors.

2.2.3. Success of pharmacotherapy along with Therapy is dependent on factors such as successful training of parents and the transfer of skills from higher levels of care to the home setting.

2.2.4. Combining medication with parent training is moderately more efficacious that medication alone for reducing serious behavioral disturbance, and more efficacious for adaptive functioning (AACAP, 2013).

2.2.5. Risperidone and aripiprazole can be used to treat irritability, aggressive behavior, deliberate self-injury and temper tantrums in children and adolescents; and aripiprazole for the treatment of irritability associated with ASD in children up to 17 years of age may be indicated (AAP, 2007; AACAP, 2013).

2.2.6. Monitoring for adverse side effects such as weight gain, metabolic syndrome, blood pressure, glucose and lipids for patients treated with these drugs is indicated.

2.2.7. Maintenance treatment in children and adolescents with ASD with aripiprazole has not been evaluated and periodic reassessment is needed to determine continued treatment with this agent.

2.2.8. SSRIs to target symptoms of repetitive behaviors, irritability, depression, tantrums, anxiety, and aggression can be helpful.

2.2.9. Slow, incremental decreases in dosage while monitoring targeted behaviors in essential practice.

2.2.10. Medication discontinuation should be coordinated with other interventions in the treatment plan.
Discharge

1. Discharge Planning

1.1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.

1.2. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:

1.2.1. An appropriate discharge plan is in place prior to discharge;

1.2.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;

1.2.3. The member agrees with the discharge plan.

1.3. For members continuing treatment, the discharge plan includes:

1.3.1. The discharge date;

1.3.2. The post-discharge level of care, and the recommended forms and frequency of treatment;

1.3.3. The names of the providers who will deliver treatment;

1.3.4. The date of the first appointment including the date of the first medication management visit;

1.3.5. The name, dose and frequency of each medication;

1.3.6. A prescription sufficient to last until the first medication management visit is provided;

1.3.7. An appointment for necessary lab tests is provided;

1.3.8. Resources to assist the member with overcoming barriers to care such as lack of transportation of child care;

1.3.9. Recommended self-help and community support services;

1.3.10. Information about what the member should do in the event of a crisis prior to the first appointment.

1.4. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.

1.5. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.

1.6. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
1.7. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.

1.8. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.

1.9. For members not continuing treatment, the discharge plan includes:
   1.9.1. The discharge date;
   1.9.2. Recommended self-help and community support services;
   1.9.3. Information about what the member should do in the event of a crisis or to resume services.
   1.9.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

**PART III: LEVEL OF CARE CRITERIA**

**Common Admission Criteria for All Levels of Care**

1. **Admission Criteria**
   1.1. The member is eligible for benefits.
   
   **AND**
   
   1.2. The member’s condition and proposed services are covered by the benefit plan.
   
   **AND**
   
   1.3. Services are within the scope of the provider's professional training and licensure.
   
   **AND**
   
   1.4. The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission).
   
   **AND**
   
   1.4.1. Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.
   
   **AND**
1.5. The member’s current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) require the intensity of services provided in the proposed level of care.

AND

1.6. Co-occurring behavioral health and medical conditions can be safely managed.

AND

1.7. Services are:

1.7.1. Consistent with generally accepted standards of clinical practice;

1.7.1.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.1.3. Consistent with Optum’s best practice guidelines;

1.7.1.4. Clinically appropriate for the member’s behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

1.8. There is a reasonable expectation that services will improve the member’s presenting problems within a reasonable period of time.

1.8.1. Improvement of the member’s condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.

1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member’s signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member’s recovery, resiliency and wellbeing.

AND

1.9. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.
2. **Common Continued Service Criteria for All Levels of Care**
   
   2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active” services must be:
      
      2.1.1. Supervised and evaluated by the admitting provider;
      
      2.1.2. Provided under an individualized treatment plan that is focused on addressing the “why now” factors, and makes use of clinical best practices;
      
      2.1.3. Reasonably expected to improve the member’s presenting problems within a reasonable period of time.
      
      **AND**
      
      2.2. The “why now” factors leading to admission have been identified and are integrated into the treatment and discharge plans.
      
      **AND**
      
      2.3. Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.
      
      **AND**
      
      2.4. The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated.

3. **Common Discharge Criteria for All Levels of Care**
   
   3.1. The continued stay criteria are no longer met. Examples include:
      
      3.1.1. The “why now” factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.
      
      3.1.2. The “why now” factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
      
      3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
      
      3.1.4. The member requires medical-surgical treatment.
      
      3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.
Outpatient

Assessment and diagnosis and active behavioral health treatments that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.

1. Admission Criteria
   1.1. (See Common Criteria for All Levels of Care)

   AND

   1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

   AND

   1.3. Acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) have occurred, and the member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

   AND

   1.4. The member is diagnosed with Autism Spectrum Disorder.

   AND

   1.5. There are acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission), and the member’s current condition can be safely, efficiently, and effectively assessed and/or treatment in this setting. Examples include:

   1.5.1. Reducing problem behavior such as aggression or self-injury;
   1.5.2. Increasing socially appropriate behavior such as reciprocity;
   1.5.3. The acquisition of communication, self-help and social skills;
   1.5.4. Learning to tolerate changes in the environment and activities.

   AND

   1.6. The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated.

2. Continued Service Criteria
   2.1. (See Common Criteria for All Levels of Care)

3. Discharge Criteria
3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include:

4.1.2.1. The goals of treatment;
4.1.2.2. The member’s preferences;
4.1.2.3. Evidence from clinical best practices which supports frequency and duration;
4.1.2.4. The need to monitor and manage imminent risk of harm to self, others, and/or property.

4.1.3. The provider informs the member of the process to be followed in the event of an after-hours emergency such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
### Intensive Outpatient Program

A structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.

The course of treatment in an Intensive Outpatient Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.

1. **Admission Criteria**
   1.1. (See Common Criteria for All Levels of Care)
   
   AND
   
   1.2. The member is not in imminent or current risk of harm to self, others, and/or property.
   
   AND
   
   1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include:
   
   1.3.1. Assessment requires frequent interaction with the member and observation of the member with others.
   
   1.3.2. The treatment plan must be frequently changed which requires that the provider have face-to-face interactions with the member several times a week.
   
   OR
1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.

1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

1.5.1.1. Maintain their current living situation;

1.5.1.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.

1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with an Intensive Outpatient Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member’s recovery.

OR

1.10. Routine attendance at the Intensive Outpatient Program is hindered by the lack of transportation.

2. Continued Service Criteria

2.1. (See Common Criteria for All Levels of Care)
3. **Discharge Criteria**

   3.1. (See Common Criteria for All Levels of Care)

4. **Clinical Best Practices**

   4.1. **Evaluation & Treatment Planning**

      4.1.1. (See Common Clinical Best Practices for All Levels of Care)

      4.1.2. The responsible provider and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than three (3) treatment days after admission.

      4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours.

   4.2. **Discharge Planning**

      4.2.1. (See Common Clinical Best Practices for All Levels of Care)
Partial Hospitalization Program

A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.

The course of treatment in a Partial Hospital Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk or harm to self, others, and/or property.

AND

1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include:

   1.3.1. Assessment requires frequent interaction with the member, and observation of the member with others.

   1.3.2. The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

   1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.
1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

1.5.1. Maintain their current living situation;
1.5.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.
1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with a Partial Hospital Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member's recovery.

OR

1.10. Routine attendance at the Partial Hospital is hindered by the lack of transportation.

1. Continued Service Criteria
   1.1. (See Common Criteria for All Levels of Care)

2. Discharge Criteria
   2.1. (See Common Criteria for All Levels of Care)

3. Clinical Best Practices
   3.1. Evaluation & Treatment Planning
       3.1.1. (See Common Clinical Best Practices for All Levels of Care)
3.1.2. The psychiatrists and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.

3.1.3. During admission, a psychiatrist is available to consult with the program during and after normal business hours.

3.1.4. A psychiatrist sees the member commensurate with the member’s needs, with no less than weekly visits.

3.2. Discharge Planning

3.2.1. (See Common Clinical Best Practices for All Levels of Care)
Residential Treatment Center

A sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.

The course of treatment in a Residential Treatment Center is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. The “why now” factors leading to admission cannot be safely, efficiently or effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors. Examples include:

1.3.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.3.2. Psychosocial and environmental problems that are likely to threaten the member’s safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

1.4. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

1.4.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
1.4.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

1.4.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

2. Continued Service Criteria

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. Discharge Criteria

3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate with the member’s needs, no later than 24 following admission.

4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours. A psychiatric consultation occurs at least weekly commensurate with the member’s needs.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.
# Inpatient

A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

## 1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The “why now” factors leading to admission, and /or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

1.2.1. A life-threatening suicide attempt;
1.2.2. Self-mutilation, injury or violence toward others or property;
1.2.3. Threat of serious harm to self or others;
1.2.4. Command hallucinations directing harm to self or others.

OR

1.3. The “why now” factors leading to admission suggest that the member's condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Example include:

1.3.1. A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.
1.3.2. A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.

OR
1.4. The “why now” factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:

1.4.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.4.2. Psychosocial and environmental problems that threaten the member’s safety or undermines engagement in a less intensive level of care.

OR

1.5. The “why now” factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

2. **Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care.

Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. **Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

4. **Clinical Best Practices**

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)
4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate within 24 hours of admission.

4.1.3. During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)

4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.

PART IV: ADDITIONAL RESOURCES

Clinical Protocols
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline.

Peer Review
Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

Second Opinion Evaluations
Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance
Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

PART V: DEFINITIONS
1. **Cognitive Behavioral Therapy (CBT)** A classification of therapies that are predicated on the idea that behavior and feelings are caused by thoughts.

2. **Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)** A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance-related disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

3. **Prevailing Medical Standards and Clinical Guidelines** means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

4. **Scientific Evidence** means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

5. **Unproven Services** Unproven Services are services including medications that are not consistent with prevailing medical research that has determined the services to not be effective for treatment of the condition and/or not to have the beneficial effect on behavioral health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed literature.

**PART VI: REFERENCES**


## PART VII: CODING

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

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<th>Limited to specific CPT and HCPCS codes?</th>
<th>X Yes</th>
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<tbody>
<tr>
<td>H0031 Mental health assessment, by non-physician</td>
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<tr>
<td>H0032 Mental health service plan development by non-physician</td>
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<td>H2012 Behavioral Health Day Treatment, per hour</td>
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<td></td>
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<tr>
<td>H2014 Skills Training and Development, per 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2019 Therapeutic Behavioral Services, per 15 minutes</td>
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<td>H0031 Mental health assessment, by non-physician</td>
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<td>H2012 Behavioral Health Day Treatment, per hour</td>
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In addition to the codes above for ABA, coverage must be provided for the following codes in Pennsylvania only.

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<td>H2027 Psychoeducational Service, per 15 minutes</td>
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### Limited to place of service (POS)?

- Yes <br> - No

### Limited to specific provider type?

- Yes <br> - No

### Limited to specific revenue codes?

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<td>100-160</td>
<td>(Range describes various all-inclusive inpatient services)</td>
</tr>
<tr>
<td>900-919</td>
<td>(Range describes various unbundled behavioral health treatments/services)</td>
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<tr>
<td>1000-1005</td>
<td>(Range describes various sites that provider 24-hour services)</td>
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### PART VIII: HISTORY

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<td>L. Urban</td>
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