# *UnitedHealthcare Plan of the River Valley, Inc.*

## Iowa Medicaid Level of Care Guidelines

***Effective Date:*** March, 2016

***Revision Date:***

## Day Treatment

**Community Mental Health Centers**

**Children/Adolescents**

**Day Treatment provides a combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive interactions between the provider and the member, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities in a licensed Community Mental Health Center. The purpose of services is to promote recovery through improved level of functioning, skill building, and disease management.**

**Day Treatment services are typically provided to members 20 years and younger with more severe mental health conditions and related functional impairments as an alternative to services in a Residential Treatment Center or Inpatient, or as a transition from these services. Day treatment is delivered a maximum of 15 hours per week to members not in inpatient, residential or group home settings.**

**The course of treatment in Day Treatment 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.**

***INSTRUCTIONS FOR USE***

*This Level of Care Guideline provides assistance in interpreting behavioral health benefits managed by UnitedHealthcare Plan of the River Valley, Inc., and is used to make coverage determinations in accordance with the terms of the member's benefits.*

*All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the member's benefits prior to use of this guideline.*

*UnitedHealthcare Plan of the River Valley, Inc. reserves the right, in its sole discretion, to modify its Level of Care Guidelines and other clinical guidelines as necessary.*

*While this Level of Care Guideline does reflect UnitedHealthcare Plan of the River Valley, Inc.'s understanding of generally accepted standards of clinical practice, it does not constitute medical advice.*

## Admission Criteria

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

AND

2. The member has been assigned a DSM diagnosis.

AND

3. The member is at risk for exclusion from normative community activities or residence due to factors such as:

   3.1. Behavioral disturbance

   3.2. Chemical dependence

   3.3. Depression

AND

4. The member exhibits some of the following symptoms. These symptoms are sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning:

   4.1. Psychiatric symptoms

   4.2. Disturbances of conduct

   4.3. Decompensating conditions affecting mental health

   4.4. Severe developmental delays

   4.5. Psychological symptoms

   4.6. Chemical dependency issues

AND

5. Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate. This includes individual or group therapy services provided by:

   5.1. A physician or psychologist in the provider's office.

   5.2. Auxiliary staff of a physician in the physician's office.

   5.3. A mental health professional employed by a community mental health center.

AND

6. The member's principle caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the member, and to enable adequate control of the member's behavior. The caretaker must be involved in the member's treatment.

6.1. If the principle caretaker is unable or unwilling to participate in the provision of services, the day treatment program must document how services will benefit the child without caretaker involvement. People who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

AND

7. The member has the capacity to benefit from the interventions provided. Examples:

   7.1. A member with a diagnosis of an intellectual disability may not be appropriate for a day treatment program if the member is unable to participate and benefit from group milieu therapy.

   7.2. A member exhibiting acute psychiatric symptoms (e.g., hallucinations) may be too ill to participate in the day treatment program.

## Continued Service Criteria

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

## Discharge Criteria

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

AND

2. The length of stay in a day treatment program for children must not exceed 180 treatment days per episode of care. If the member's condition requires a longer stay, document the rationale for continued stay in the member's case record and in the treatment plan every 30 calendar days after the first 180 treatment days.

AND

3. Discharge criteria for the day treatment program for children must incorporate at least the following indicators:

   3.1. If the patient improves:

      3.1.1. The member's clinical condition has improved, as shown by symptom relief, behavioral control, or indication of mastery of skills at the member's developmental level.

      3.1.2. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

      3.1.3. Treatment goals in the individualized treatment plan have been achieved.

      3.1.4. An aftercare plan has been developed that is appropriate to the member's needs, and the member and the family, custodian, or guardian has agreed to it.

OR

3.2. If the member does not improve:

3.2.1. The member's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

3.2.2. The member, the family, or the custodian has not complied with treatment or with program rules.

3.2.3. Post-discharge services must include a plan for discharge that provides appropriate continuity of care.

## Clinical Best Practices

1. Evaluation & Treatment Planning

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

1.2. There is an interdisciplinary team responsible for completing a team assessment and plan of care. This team is comprised of:

1.2.1. A board eligible or board-certified psychiatrist, or

1.2.2. A clinical psychologist who has a doctoral degree and a physician license to practice in medicine or osteopathy, or

1.2.3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state, and

1.2.4. A social worker with a master's degree and one year experience;

1.2.5. A registered nurse with training or one year experience in mental health;

1.2.6. A licensed occupational therapist with training or one year experience in mental health; and

1.2.7. A psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

1.3. The member shall receive a formal, comprehensive bio-psychosocial assessment of day treatment needs. If applicable, include a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. Address in the assessment whether medical causes for the child's behavior have been ruled out.

1.3.1. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same. If not, parts of the assessment which reflect current functioning may be used as an update.

1.4. The team must assess:

1.4.1. Immediate and long- range needs, development, strengths and liabilities.

1.4.2. Potential resources in the family.

1.4.3. Treatment objectives

1.4.4. Appropriate therapeutic modalities

1.5. Using the assessment, the team produces a comprehensive summation, including the findings of all assessments performed. Using the summary, the team develops a plan of care, including treatment goals.

1.6. A preliminary plan of care is developed within three days of program participation after admission and updated within 30 calendar days by a comprehensive, formalized plan using the comprehensive assessment.

1.7. This plan of care should reflect the member's diagnosis and the member's strengths and weaknesses and identify areas of therapeutic focus. Relate the treatment goals (general statements of member outcomes) to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Outline:

1.7.1. The hours and frequency the member will participate in the program.

1.7.2. The type of services the member will receive.

1.7.3. The expected duration of the program.

1.7.4. Objectives shall be related to the goal and have specific anticipated outcomes. State the methods that will be used to pursue the objectives. Review and revise as needed the plan but review at least every 30 calendar days.

2. Treatment Delivery

2.1. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family-focused. The overall expected outcome is clinically adaptive behavior on the part of the member and the family. At a minimum, day treatment services are expected to improve the member's condition, restore the condition to the level of functioning before onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization.

2.2. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

2.3. As day treatment programs for adults and children have different focuses, persons aged 18 through age 20 with chronic mental illness may be better served by the adult day treatment program. As a result, persons between the ages of 18 and 20 with chronic mental illness may access the day treatment program which best meets their needs, day treatment for adults or day treatment for children.

2.4. Day treatment programs shall use an integrated, comprehensive, and complimentary schedule of therapeutic activities, and shall have the capacity to treat a wide array of clinical conditions.

2.5. The day treatment program shall offer a coordinated, consistent array of scheduled therapeutic services and activities. These may include:

2.5.1. Counseling or psychotherapy,

2.5.2. Theme groups,

2.5.3. Social skills development,

2.5.4. Behavior management, and

2.5.5. Other adjunctive therapies.

2.6. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each member shall consist of active treatment components which are determined by the individual treatment plan based upon a comprehensive evaluation of member needs, as well as specifically addressing the targeted problems of the population served.

2.6.1. Active treatment has been defined as treatment in which the therapist assumes significant responsibility and often intervenes.

2.7. Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment.

2.7.1. Medicaid will not make separate payment for family therapy services. Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

2.8. Therapeutic activities will be scheduled according to the needs of the members, both individually and as a group.

2.9. Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

2.10. The program shall maintain a distinct clinical record for each member admitted. At a minimum, documentation shall include:

2.10.1. The specific services rendered,

2.10.2. The date and actual time services were rendered,

2.10.3. Who rendered the services,

2.10.4. The setting in which the services were rendered,

2.10.5. The amount of time it took to deliver the services,

2.10.6. The relationship of the services to the treatment regimen described in the plan of care, and

2.10.7. Updates describing the member's progress.

2.11. Day treatment services for children shall be a time-limited, goal-oriented, active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu.

2.11.1. Time-limited means that the member is not expected to need services indefinitely, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the member in order that the service is no longer necessary.

3. Discharge Planning

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

3.2. Consistently monitor indicators for discharge planning, including:

3.2.1. Recommended follow-up goals.

3.2.2. Provision for future services.

4. Limitations and Exclusions

4.1. The day treatment program may include an educational component as an additional service. The member's educational needs shall be served without conflict from the day treatment program.

4.2. Hours in which the member is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

4.2.1. The member attends the day treatment program from 9:00 a.m. to 3:00 p.m. The member attends the educational component from 9:00 a.m. to noon.

4.2.2. The hours the member attended the educational component are deducted from the day treatment hours. The billable day treatment hours for Medicaid are three hours. The day treatment program may wish to pursue funding of educational hours from local school districts.

## References

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## History

| Revision Date | Name | Revision Notes |
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| 2/2016 | L. Urban | Version 1-Final |
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