



LEVEL OF CARE GUIDELINES: COMMON CRITERIA & CLINICAL BEST PRACTICES FOR ALL LEVELS OF CARE

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INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing¹ for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”).

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

For more information on guiding principles for the *Level of Care Guidelines* and their development, approval, dissemination, and use, please see the *Introduction to the Level of Care Guidelines*, available at: www.providerexpress.com > Clinical Resources > Level of Care Guidelines.

Before using this guideline, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.

COMMON ADMISSION CRITERIA FOR ALL LEVELS OF CARE

- The member is eligible for benefits.
AND
- The member’s condition and proposed service(s) are covered by the benefit plan.
AND
- Service(s) are within the scope of the provider’s professional training and licensure.
AND

¹ The terms “recovery” and “resiliency” are used throughout the Level of Care Guidelines. SAMHSA defines “recovery” as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines “resilience” as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines “recovery” as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

- The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
 - Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.
 AND
- 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 the factors leading to admission require the intensity of services provided in the proposed level of care.
 AND
- Co-occurring behavioral health and medical conditions can be safely managed.
 AND
- Service(s) are the following:
 - Consistent with generally accepted standards of clinical practice;
 - Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
 - Consistent with Optum’s best practice guidelines;
 - Clinically appropriate for the member’s behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.
 AND
- There is a reasonable expectation that service(s) will improve the member’s presenting problems within a reasonable period of time.
 - Improvement of the member’s condition is indicated by the reduction or control of the signs and symptoms that necessitated treatment in a level of care.
 - 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.

COMMON CONTINUED SERVICE CRITERIA FOR ALL LEVELS OF CARE

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active”, service(s) must be as follows:
 - Supervised and evaluated by the admitting provider;
 - Provided under an individualized treatment plan that is focused on addressing the factors leading to admission, and makes use of clinical best practices;
 - Reasonably expected to improve the member’s presenting problems within a reasonable period of time.
 AND
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.
 AND
- Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.
 AND
- The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated.

COMMON DISCHARGE CRITERIA FOR ALL LEVELS OF CARE

- The continued stay criteria are no longer met. Examples include:
 - The 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.
 - The factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
 - Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
 - The member requires medical/surgical treatment.
 - The member is unwilling or unable to participate in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES FOR ALL LEVELS OF CARE

Evaluation & Treatment Planning

- The initial evaluation:
 - 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;
 - Focuses on the member’s specific needs;
 - Identifies the member’s goals and expectations;

- Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- The provider collects information from the member and other sources, and completes an initial evaluation of the following:
 - The member's chief complaint;
 - The history of the presenting illness;
 - The factors leading to the request for service;
 - The member's mental status;
 - The member's current level of functioning;
 - Urgent needs, including those related to the risk of harm to self, others, and/or property;
 - The member's use of alcohol, tobacco, or drugs;
 - Co-occurring behavioral health and physical conditions;
 - The member's history of behavioral health services;
 - The member's history of trauma;
 - The member's medical history and current physical health status;
 - The member's developmental history;
 - Pertinent current and historical life information;
 - The member's strengths;
 - Barriers to care;
 - The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
 - The member's broader recovery, resiliency, and wellbeing goals.
- The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
- The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan. The treatment plan addresses the following:
 - The short- and long-term goals of treatment;
 - The type, amount, frequency, and duration of treatment;
 - The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and directly related to the factors leading to admission;
 - How the member's family and other natural resources will participate in treatment when clinically indicated;
 - How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.
- 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. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- 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.
- Treatment focuses on addressing the factors precipitating admission 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.
- The treatment plan and level of care are reassessed when the member's condition improves, worsens, or does not respond to treatment.
 - When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
 - 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.
- 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.

Discharge Planning

- The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
 - An appropriate discharge plan is in place prior to discharge;
 - The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
 - The member agrees with the discharge plan.

- For members continuing treatment:
 - The discharge plan includes the following:
 - The discharge date;
 - The post-discharge level of care, and the recommended forms and frequency of treatment;
 - The name(s) of the provider(s) who will deliver treatment;
 - The date of the first appointment, including the date of the first medication management visit;
 - The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
 - An appointment for necessary lab tests;
 - Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
 - Recommended self-help and community support services;
 - Information about what the member should do in the event of a crisis prior to the first appointment.
- For members not continuing treatment:
 - The discharge plan includes the following:
 - The discharge date;
 - Recommended self-help and community support services;
 - Information about what the member should do in the event of a crisis or to resume services.
 - The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

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HISTORY/REVISION INFORMATION

Date	Action/Description
01/10/2017	• Version 1 (Approved by UMC)
02/07/2018	• Version 2 (Approved by UMC)