



LEVEL OF CARE GUIDELINES: MENTAL HEALTH CONDITIONS

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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.

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.

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
- 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.

GUIDELINES: OUTPATIENT

Outpatient: *Assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting or in the member's home. The course of treatment in Outpatient is focused on addressing the 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 factors that precipitated admission no longer require treatment. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes.*

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer (53+ minutes, per the CPT Time Rule). Extended outpatient sessions may require prior authorization before services are received, except in extenuating circumstances, such as a crisis. Please check the member's specific plan document.

Home-based assessment and treatment are separate services, and the findings of a home-based assessment may or may not support the need for home-based treatment.

Outpatient Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- The member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

Coverage for extended outpatient sessions lasting longer than 60 minutes (53+ minutes, per the CPT Time Rule) may be indicated in the following non-routine circumstances:

- The member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and an extended outpatient session is appropriate for providing rapid and time-limited assessment and stabilization.
 - Consider extending coverage for acute crisis situations in 30-minute increments when clinically indicated.
 - Prior authorization is not required when there is an acute crisis.

- An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or an acute worsening of the member's condition that would likely require a more intensive level of care if the outpatient session is not extended.
- Periodic involvement of children, adolescent, or geriatric members' family in a psychotherapy sessions when such involvement is essential to the member's progress (e.g., when psychoeducation or parent management skills are provided).
 - This is not synonymous with marital or family therapy.
- An extended session is otherwise needed to address new symptoms of the reemergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without an extended outpatient session, the new-re-emerging symptoms are likely to worsen and require a more intensive level of care.

Extended outpatient sessions may be covered in the following circumstances, as indicated by the member's condition and specific treatment needs:

- The member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Specific Phobia, and is being treated with Prolonged Exposure Therapy.
- The member is being treated with Eye Movement Desensitization and Reprocessing (EMDR) or Traumatic Incident Reduction (TIR) for Posttraumatic Stress Disorder (PTSD).
- The member's Borderline Personality Disorder diagnosis is a covered condition, and the member is being treated with Dialectical Behavior Therapy (DBT).

Home-Based outpatient assessment and/or treatment may be covered when the member is homebound. A member is homebound when:

- A physical condition restricts the member's ability to leave his/her residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
- A behavioral health condition is manifested in part by an inability to leave home, or is such that it would not be considered safe for the member to leave home unattended.

Home-based outpatient assessment may be covered when:

- An assessment of the acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
- An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

Home-based outpatient treatment may be covered when:

- The member's signs and symptoms are primarily or exclusively experienced at home.
- The factors leading to the admission undermine the member's participation in treatment at an ambulatory setting.

Outpatient Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Outpatient Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Outpatient Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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 the following:
 - The goals of treatment;
 - The member's preferences;
 - Evidence from clinical best practices which supports frequency and duration;
 - The need to monitor and manage imminent risk of harm to self, others, and/or property.
- 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.
- The following conditions may support home-based assessment and/or treatment:
 - Agoraphobia or Panic Disorder;
 - Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member's judgment and decision making, and therefore the member's safety;

- Acute depression with severe vegetative symptoms;
- Behavioral health problems associated with medical problems that render the member homebound.

GUIDELINES: INTENSIVE-OUTPATIENT PROGRAM (IOP)

Intensive-Outpatient Program (IOP): 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 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.

Intensive-Outpatient Program (IOP) Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
AND
- 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 the following:
 - Assessment requires frequent interaction with the member and observation of the member with others.
 - 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
- The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
 - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
 - The member has been unable to access or utilize the member's family or other natural resources on his or her own.
- OR
- 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:
 - Maintain their current living situation;
 - Return to work or school.
- OR
- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of skills include those that help the member:
 - Assistance with developing the skills needed to self-manage medications;
 - 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

- Overnight housing is covered by the benefit plan.
AND
- The treatment setting is separate from the housing.
AND
- Either of the following apply:
 - An unsupportive or high-risk living situation is undermining the member's recovery;
 - Routine attendance at the intensive outpatient program is hindered by a lack of transportation.

Intensive-Outpatient Program (IOP) Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Intensive-Outpatient Program (IOP) Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Intensive-Outpatient Program (IOP) Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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.
- During admission, a psychiatrist is available to consult with the program during and after normal program hours.

GUIDELINES: DAY TREATMENT PROGRAM

Day Treatment: A structured program most commonly found in state-funded benefit plans that maintains hours of service for at least 3 hours per day, at least 4 days per week. 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. 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 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. Examples of at-risk members include children and adolescents with Serious Emotional Disturbance², and adults with Serious Mental Illness³.

The course of treatment in Day Treatment is focused on addressing the 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.

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

Day Treatment Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member has a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI)
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 3 hours per day, 4 days per week. Examples include:
 - Assessment requires frequent interaction with the member, and observation of the member with others.
 - 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
- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include:
 - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.

² According to Federal Register Volume 62, Number 193, Serious Emotional Disturbance occurs in persons from birth up to the age of 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with the DSM that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

³ According to Federal Register 58, Number 96, the definition of Serious Mental Illness (SMI) includes persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental, dementias, mental disorders due to a medical condition and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

- The member has been unable to access or utilize the member's family or other natural resources on his or her own.

OR

- 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:
 - Maintain his or her current living situation;
 - Return to work or school.

OR

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

Criteria for Overnight Housing Coupled with a Day Treatment Program

- Overnight housing is covered by the benefit plan.
AND
- The treatment setting is separate from the housing.
AND
- Either of the following apply:
 - An unsupportive or high-risk living situation is undermining the member's recovery;
 - Routine attendance at Day Treatment is hindered by a lack of transportation.

Day Treatment Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Day Treatment Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Day Treatment Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The psychiatrist and treatment team complete the initial evaluation commensurate with the member's needs, no later than 24 hours following admission.
- During admission, a psychiatrist is available to consult with the program during and after normal business hours.
- A psychiatrist sees the member commensurate with the member's needs, with no less than weekly visits.

GUIDELINES: PARTIAL HOSPITAL PROGRAM (PHP)

Partial Hospital 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. While a Partial Hospital Program generally maintains at least 20 hours of service per week, the frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.*

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 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.

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.

Partial Hospital Program Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include the following:
 - Assessment requires frequent interaction with the member, and observation of the member with others.
 - The treatment plan must be changed frequently, which requires that the provider have face-to-face interactions with the members several times a week.
- OR
- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include the following:
 - 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.
 - The member has been unable to access or utilize family or other natural resources on his or her own.
- OR
- 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:
 - Maintain their current living situation;
 - Return to work or school.
- OR
- 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 the following:
 - Assistance with developing the skills needed to self-manage medication.
 - 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

- Overnight housing is covered by the benefit plan.
- AND
- The treatment setting is separate from the housing.
- AND
- Either of the following apply:
 - An unsupportive or high-risk living situation is undermining the member's recovery.
 - Routine attendance at the partial hospital program is hindered by the lack of transportation.

Partial Hospital Program Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Partial Hospital Program Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Partial Hospital Program Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The psychiatrist and treatment team complete the initial evaluation commensurate with the member's needs, no later than 24 hours following admission.
- During admission, a psychiatrist is available to consult with the program during and after normal business hours.
- A psychiatrist sees the member commensurate with the member's needs, with no less than weekly visits.
- The frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

GUIDELINES: RESIDENTIAL TREATMENT CENTER (RTC)

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 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.

Residential Treatment Center Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
AND
- The 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 the following:
 - 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.
 - 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.

Residential Treatment Center Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)
AND
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, and ambulating);
 - Health-related services 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;
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Residential Treatment Center Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Residential Treatment Center Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation commensurate with the member's needs, no later than 24 hours following admission.
- 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.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

GUIDELINES: CRISIS STABILIZATION & ASSESSMENT

Crisis Stabilization & Assessment: A program in which the factors that precipitated the need for service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care, or it is determined that the member's condition requires treatment in a more intensive level of care.

There are different types of Crisis Stabilization & Assessment programs. For example, mobile crisis teams are designed to rapidly triage members in crisis who are unable or unwilling to go to an Emergency Room or a facility-based Crisis Stabilization & Assessment program.

More extended and extensive services are offered in Crisis Stabilization & Assessment programs which employ behavioral health professionals and peers to deliver a range of 24-hour services over the course of several days. These programs may be freestanding or co-located with another facility-based program, and the services they provide may include crisis stabilization with/without medication management, peer support, recovery/resiliency planning, an organized sobriety group, social and recreational activities, facilitated access to the next appropriate level of care, and information about community resources.

Crisis Stabilization & Assessment Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

Crisis Stabilization & Assessment Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Crisis Stabilization & Assessment Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Crisis Stabilization & Assessment Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The focus of evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.
- The evaluation addresses the following:
 - Presenting concerns;
 - Urgent needs, including those related to the risk of harm to self, others, and/or property;
 - The history of crises, including:
 - Response to prior interventions;
 - Issues since last crisis stabilization;
 - Current living situation;
 - Availability of supports;
 - Current treatment;
 - Use of alcohol or drugs;
 - Co-occurring behavioral health or medical conditions.
- The treatment plan addresses the following:
 - The member's urgent needs;
 - Immediate services needed to respond to the current crisis;
 - How the member's family and other natural resources will be involved in resolving the crisis when clinically indicated;
 - How the member will be transitioned to other services.

GUIDELINES: 23-HOUR OBSERVATION

23 Hour Observation: *A program that provides a medically-safe environment for up to 23 hours during which the factors that precipitated the need for service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or it is determined that the member's condition requires treatment in a more intensive level of care.*

23 Hour Observation Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

23 Hour Observation Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

23 Hour Observation Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

23 Hour Observation Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)

- The focus of evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.

GUIDELINES: INPATIENT

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 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.

Inpatient Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The 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 the following:
 - A life-threatening suicide attempt;
 - Self-mutilation, injury, or violence towards others or property;
 - Treat of serious harm to self or others;
 - Command hallucinations directing harm to self or others.
- OR
- The 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. Examples include:
 - A physical cause for the member's signs and symptoms cannot be ruled out in a less intensive setting.
 - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.
- OR
- The 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:
 - Acute impairment of behavior or cognition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered.
 - Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care.
- OR
- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

Inpatient Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)
AND
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
 - Health-related services 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;
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Inpatient Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Inpatient Clinical Best Practices

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

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

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HISTORY/REVISION INFORMATION

Date	Action/Description
01/10/2017	<ul style="list-style-type: none"> Version 1 (Approved by UMC)
05/09/2017	<ul style="list-style-type: none"> Version 2 (Approved by UMC)
02/07/2018	<ul style="list-style-type: none"> Version 3 (Approved by UMC)