INTRODUCTION

The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing 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.

DAY TREATMENT

DAY TREATMENT is non-residential care provided on prescription of a physician in a clinically supervised setting that provides case management and an integrated system of individual, family, and group counseling or therapy or other services assembled pursuant to an individually prepared plan of treatment that is based on a multi-disciplinary assessment of the member and his or her family and is designed to alleviate emotional or behavioral problems experienced by the member related to his or her mental illness or severe emotional disturbance.

1 The terms “recovery” and resiliency” are used throughout the Psychological and Neuropsychological Testing 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.
Level I services are designed to assist members whose needs are principally derived from conduct disorders or oppositional disorders, and are best met by extended participation in a therapeutic milieu or structured services including individual, group and family counseling, educational support or direct academic instruction and recreational therapy.

Level II services are designed to assist members whose needs are principally derived from intransigent and severe mental health disorders and are best met by intense, extended psychiatric or psychotherapeutic treatment in combination with a continuum of other individual and family support services.

Level III services are designed to assist members whose needs are principally derived from an acute episode of a mental health disorder and are best met by intense, short-term treatment in a psychiatric or psychotherapeutic setting.

1. Admission Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":
     AND
   • see “Admission Criteria” in the Level of Care Guideline, Day Treatment:
     AND
   • The member has a primary diagnosis of a mental health condition or Severe Emotional Disturbance.
   • The member is unable to obtain benefit from a less restrictive program.
   • Based upon information available at the time of referral, there is a reasonable likelihood that the member will benefit from the services being offered by the program.
   • The member meets 1 or more of the following criteria:
     o The member is exhibiting significant dysfunction in 2 or more of the basic domains of their life and requires services offered by the program in order to acquire or restore the skills necessary to perform in those areas; or
     o Be in need of a period of transition from a hospital, residential treatment center or other institutional setting as part of the process of returning to live in the community; or
     o Be experiencing a period of acute crisis or other severe stress, so that without the level of services provided by the program, the member would be at high risk of hospitalization or other institutional placement.
   AND
   • Services are medically necessary

2. Continued Service Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":

3. Discharge Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":

4. Clinical Best Practices
   • see "Common Criteria and Best Practices for All Levels of Care":
   • see “Clinical Best Practices” in the Level of Care Guideline, Day Treatment:
   • The provider assembles a multidisciplinary and multi-agency treatment team, and completes an initial evaluation within 5 business days of admission.
   • The treatment team prepares a treatment plan within 30 calendar days after admission for Level I and II services, or within 10 calendar days after admission for Level III services.
The treatment team reviews case progress according to the following schedule:

- Level I services: within 30 calendar days following approval of the treatment plan and every 60 days thereafter.
- Level II services: within 30 calendar days following approval of the treatment plan and every month thereafter.
- Level III services: within 14 calendar days following approval of the treatment plan and every month thereafter.
- For all levels, progress may be reviewed more frequently if indicated by the member’s condition or family’s condition, or upon request of the member, the member’s parent, guardian, attorney, program staff, county department, or the department responsible for supervising the member pursuant to a court order. Request for more frequent review is made in writing and is documented in the member’s record.

- Unless the member poses an immediate risk of harm to other clients or staff, the program provides the member, his or her parent or guardian, and other agencies providing services to the member with at least 7 days prior notice of the intent to end services.
- When the member has been placed in the program by order of court, the program provides the court and the social worker responsible for supervising the implementation of the court order with 14 days prior notice of the intent to end services, unless the member poses an immediate risk of harm to other clients or staff, in order to permit the court to enter an alternative order regarding the care of the member.

REFERENCES*


*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines and in the related Behavioral Clinical Policy

HISTORY/REVISION INFORMATION

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<td>January, 2015</td>
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<td>January, 2016</td>
<td>Version 4</td>
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<td>January, 2017</td>
<td>Version 5</td>
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i Per Wisconsin DHS 107.32 “Severe Emotional Disturbance” includes emotional and behavioral problems which:

1. Are expected to persist for at least one year;
2. Have significantly impaired the person’s functioning for 6 months or more and, without treatment, are likely to continue for a year or more. Areas of functioning include: developmentally appropriate self-care; ability to build or maintain satisfactory relationships with peers and adults; self-direction, including behavioral controls, decision-making, judgment and value systems; capacity to live in a family or family equivalent; and learning ability, or meeting the definition of “child with exceptional educational needs” under ch. PI 1 and s. 115.76 (3), Stats.;
3. Require the person to receive services from 2 or more of the following service systems: mental health, social services, child protective services, juvenile justice and special education; and

Include mental or emotional disturbances diagnosable under DSM-III-R. Adult diagnostic categories appropriate for children and adolescents are organic mental disorders, psychoactive substance use disorders, schizophrenia, mood disorders, schizophreniaform disorders, somatoform disorders, sexual disorders, adjustment disorder, personality disorders and psychological factors affecting physical condition. Disorders usually first evident in infancy, childhood and adolescence include pervasive developmental disorders (Axis II), conduct disorder, anxiety disorders of childhood or adolescence and tic disorders.

ii Per the UnitedHealthcare Community Plan of Wisconsin Provider Manual, medically necessary services or supplies are those that meet the following standards:

1. Is consistent with the member’s symptoms or with prevention, diagnosis or treatment of the recipient’s illness, injury or disability.
2. Is consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided.
3. Is appropriate with regard to generally accepted standards of medical practice.
4. Is not medically contraindicated with regard to the recipient’s diagnoses, the member’s symptoms or other medically necessary services being provided to the member.

5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature.

6. Is not duplicative with respect to other services being provided to the member.

7. Is not solely for the convenience of the member, the recipient’s family, or a provider.

8. With respect to Prior Authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member.

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the member.