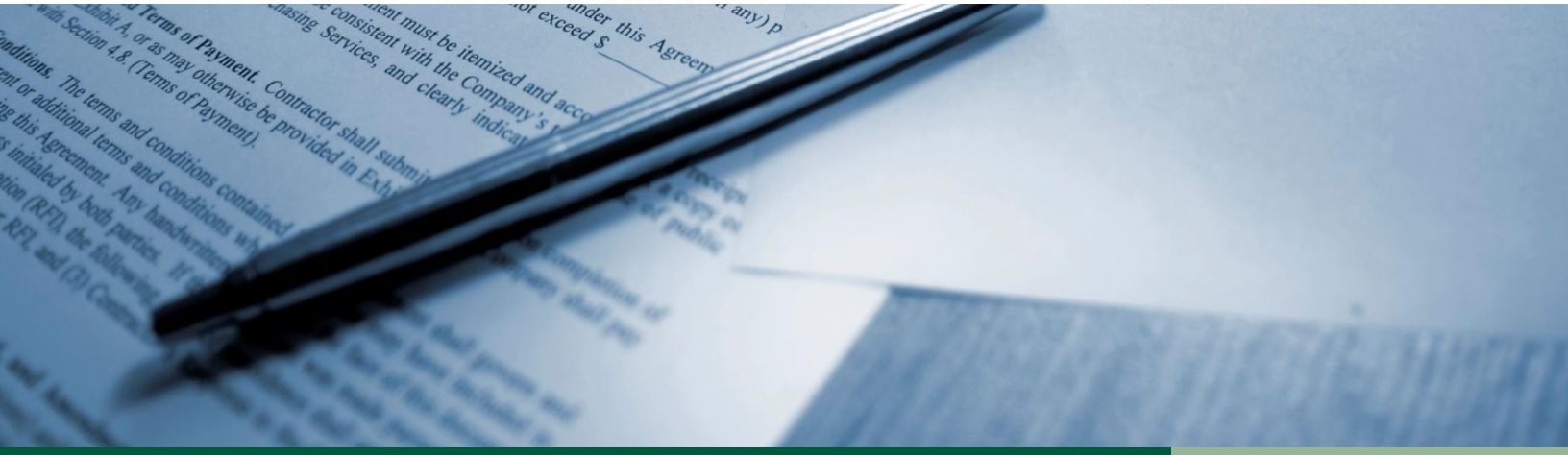
MINES & ASSOCIATES

Utilization Criteria Manual

2022



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Introduction to Utilization Review Criteria

In keeping with MINES & Associates' (MINES) commitment since 1988 to provide the most efficacious care possible, in the most appropriate level of care, the following review criteria have been developed to articulate the systematic approach that MINES utilizes in determining the appropriate level of care for its clients. Throughout the criteria, client safety and client welfare have continually been of paramount importance and the ultimate benchmark of the decisions that have been made.

In the development of these criteria, MINES has employed a comprehensive review strategy to ensure that the criteria developed would represent the most current evidenced-based information available in the disciplines that provide the foundation for behavioral health treatment. Toward that end, MINES has reviewed and periodically updated, in detail, the criteria developed by other managed care systems that exists in the public domain, completed a systematic review of the scientific literature for evidence-based treatment, reviewed professional organization recommendations and protocols such as ASAM, LOCUS, COLOCUS, the American Psychiatric Association practice guidelines, various accreditation agency criteria, state laws, drawn upon the clinical experience and expertise of our clinical staff, the experience of other external providers and the experience of our own clients. The review process has been extensive and involved countless numbers of hours in dialogue over each element in the criteria to ensure its value and appropriateness in the clinical work that we do. We have maintained, throughout, our focus upon our mission of making a positive contribution to the welfare of the clients we serve in the most appropriate, medically and psychologically necessary level of care. To-date, we have incorporated the best of what the field has to offer and are grateful for the contributions of all involved in the development of these criteria. As part of our efforts to provide the most efficacious level of care and advance the behavioral healthcare field, we encourage other managed care entities, providers, and researchers to use any of our criteria that meets their clinical needs and standards as well as to give us feedback regarding the research basis to either confirm or disconfirm the criteria in this document.

Notifications

These criteria do not constitute medical or psychological advice. When the scientific/evidenced-based literature is inconclusive MINES reserves the right to consult expert opinion, recommendations, or standards of care. In addition, expert opinions may be sought to determine whether services are medically/psychologically necessary. It is MINES's sole authority and decision to choose experts or other options and when to do so.

MINES does not dictate treatment; that is between the patient and the provider. MINES authorizes appropriate levels of care. MINES represents self-insured entities and provides managed behavioral healthcare services for those entities. All claims and fiscal responsibility for those claims are the self-insured entity's responsibility. MINES does not verify eligibility or benefits. It is the provider's responsibility to call the third-party administrator for eligibility and benefit verification and to comply with all pre-certification, concurrent review, and related processes and procedures.

MINES reserves the right, in its sole discretion, to modify the criteria as necessary from time to time, given advances in the multi-disciplinary fields germane to behavioral healthcare services and levels of care.

Levels of Care

The criteria are designed to represent the clinical considerations necessary in order to apply, appropriately, on an individualized basis, the full continuum of psychological/psychiatric and substance use treatment services.

The arenas of psychological/psychiatric care include criteria for:

- Outpatient mental health
- Intensive outpatient treatment
- Partial hospitalization/day treatment
- Residential psychiatric care
- Inpatient psychiatric care

The arenas of substance use care include criteria for:

- Outpatient substance abuse treatment
- Intensive outpatient treatment
- Social detoxification
- Medical detoxification
- Partial hospitalization/day treatment
- Residential substance use care
- Medically assisted treatment

Due to constraints required by the **Mental Health Parity and Addiction Equity Act** of 2008 (MHPAEA), outpatient and intensive outpatient criteria may only be used for disease management programs specific to certain diagnoses or for continued care after inpatient or residential treatment under a complex case management protocol. Examples of disease management programs may include diagnoses such as depression or substance use disorders. It is uncommon, however, there are specific plan exceptions to IOP not requiring authorization. Please check with the plan administrator.

Medical Necessity: The American Medical Association defined medical necessity as: "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease, or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider." The "prudent physician" standard of medical necessity ensures that physicians are able to use their expertise and exercise discretion, consistent with good medical care, in determining the medical necessity for care to be provided for each individual patient. MINES further adds, "prudent mental health or substance use disorder professional" to the standard of medical necessity to broaden and ensure that all providers of care are able to use their expertise in determining medical and psychological necessity in the behavioral health care arena. (American Medical Association's statement to the Institute of Medicine's Committee on Determinations of Essential Health Benefits, 2011 http://www.nationalacademies.org/hmd/~/media/8D03963CAEB24450947C1AEC0CAECD85.ash).

Further definition refinements: Mental Health/Substance Use Disorder services should not be primarily for the avoidance of incarceration of the Covered Individual or to satisfy a programmatic length of stay, which refers to a pre-determined number of days or visits for a program's length of stay regardless of

clinical/medical necessity or individual differences regarding frequency, intensity and/or duration of symptoms related to the individual's diagnosis.

There should be a reasonable expectation that the client's or patient's (the terms patient and client to be used interchangeably for the purposes of these criteria) illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the Covered Individual's illness. In many areas of medicine and psychology, acute symptoms are treated, and the underlying condition cannot be cured. An example would be hospitalization for diabetic symptoms where the patient is treated and released to outpatient care and management as the underlying condition is not going to be cured at this time in medical care. There are many diagnoses in behavioral health that are similar in their chronicity and for which there is no underlying condition cure at this time, just ongoing management. Substance use disorders, some types of depression, and anxiety disorders are diagnoses to consider. Custodial care is not typically a Covered Service. These services are subject to each self-insured entity's Summary Plan Design (SPD) and MINES does not have authority over any plan design.

Medical necessity determinations are applications of criteria to authorize a level of care and do not ensure that payment will be made by the payor. MINES asks consultative questions of the provider regarding level of care criteria, discharge planning, patient treatment history, and other relevant factors. These factors include and are not limited to: are services within accepted standards of care, are clinically appropriate, are likely to produce significant positive outcomes and no more likely to produce negative outcomes to the illness/disorder or overall patient health than any alternative treatment regime, are not for convenience of the provider or patient, are cost-effective and provided in the least restrictive and most clinically appropriate environment.

Maximum (maximal) Medical Improvement (MMI): A patient/client is considered to have reached maximal medical improvement (MMI) when a physician (or licensed mental health provider) has determined that *no additional medical treatment is likely to improve* the patient/client's function. This does not mean that the patient/client may not need continued maintenance treatment and may continue to receive appropriate medical/psychological/psychiatric care such as psychotherapy or medication management. MINES notes that the most appropriate level of care that manages the symptoms and returns the patient to their baseline functioning is warranted for chronic psychological/psychiatric conditions (e.g., eating disorders such as anorexia nervosa, treatment-resistant depression and substance use disorders) that have been treatment-resistant at higher levels of care. Treatment resistance is defined as the failure to improve at the various levels of care and treatment episodes/modalities/techniques. Patient/client motivation for change is a separate psychological factor from maximum medical improvement. It is assumed that MMI has been reached and despite the efforts of the patient/client to comply with treatment they are unable to benefit from higher levels of care. Noncompliance with care is a separate consideration factor.

There are assumptions that higher (more restrictive) levels of care are more effective than lower (less restrictive) levels of care that were discussed in a recent court case (David Wit, et al v. United Behavioral Health., Gary Alexander, et al., v. United Behavioral Health, Case No. 14-cv-05337 JCS). There is no evidence in general to support this assumption. On a case by case basis, patient safety issues and welfare certainly warrant higher levels of care, also known as more structured levels of care, and lower/less structured levels would be contraindicated. There is also an assumption that the most conservative (i.e., higher/more structured levels) should be the default. This is also not supported by evidence-based practice

or literature. In addition, there are ethical principles of patient autonomy that are sometimes in juxtaposition with principles of paternalism. There are also clinical arguments based on role theory (being an inpatient and acting accordingly) versus being competent to manage one's life (with help). Self-efficacy research also has a bearing on a patient's success at various levels of care. Self-efficacy is predictive of a person's probability of executing a behavior. In treatment, the application would be for example, "what is the probability I can maintain my sobriety under a specific condition?" Internal and external locus of control perceptions also have explanatory relevance for understanding patient/client perceptions of their own agency in maintaining treatment gains as well as the source of change. Another recurring and unsupported treatment assumption is that patients/clients can be "motivated" by the treatment provider to change based on higher levels of care. This is just not supported in the literature or clinical practice. The point of this section is that from time to time our assumptions and the providers' assumptions on these very issues may vary and it is incumbent on all of us to be able to have a clinical dialogue, be aware of the patient's welfare and reach an informed decision that meets the specific individual's clinical needs.

Complex Case Management is used to follow inpatient, residential, and Partial Hospitalization Program (PHP) patients/clients for a minimum of a year after their discharge as this is considered by MINES to be an episode of care which includes aftercare follow up and consultation with the patient/client, the providers and the patient/client's family. The frequency of this follow-up may include weekly for the first month, monthly until month six (6) and quarterly after that depending on stability and adherence to treatment. This is provided by way of example, not prescription, as individual clinical necessity will dictate the structure of the case management follow up regarding the treatment plan.

Integrated Case Management assists complex patients to regain physical and mental health. This is a cross-disciplinary approach to addressing and reducing complexity-based health barriers in multiple domains. Patients/clients that are appropriate for this approach typically have a number of poorly controlled health conditions, which may involve both general medical and mental health issues and/or social and health system challenges.

Levels of Consultation and Appeal

MINES endeavors to collaborate on the levels of care with the provider(s). Provider, as used in these guidelines, refers to individual practitioners, facilities, hospitals, and treatment teams as is appropriate for a given patient's care. To that end, there are three levels of consultation that may occur:

1. **Case Manager Consultation:** The case manager and treatment team share clinical information and treatment plan. This consultation is to provide mutual information on the patient in order to determine the appropriate level of care and medical necessity.
2. **Peer to Peer Consultation:** If the provider(s) clinical team or individual provider disagree with the level of care determination based on the patient's symptoms, the provider can request a peer to peer consultation to further review the clinical information, the evidence-based practice that informs the treatment and level of care decision, and for the case management team to either uphold or revise the determination of level of care.
3. **Doctor to Doctor (Doc to Doc) Consultation:** If the provider(s) disagrees with the peer to peer consultation, a request for a Doc to Doc consultation for further discussion and review of the clinical symptoms, the evidenced-based practice that informs the level of care determination, and for the case management team to either continue or revise the determination of level of care.

If there is still disagreement regarding level of care, then the provider(s) have access to two levels of formal appeal:

1. **Appeal Level One (1):** For the appeal process to occur the provider(s) must formulate a letter explaining the levels of care it is appealing, the dates of service it is appealing, and who to be in contact with to give the determination. Additional information to be included is the patient's full chart to include, but not limited to, group notes, therapist's notes, family session notes, doctor notes, nurse notes, medication records, vitals, withdrawal protocols (if applicable), labs, and any other important information to make this determination. The filing of the appeal must be within the time parameters set by the specific Payor in its Summary Plan Design (SPD). All information should be mailed to:

   MINES and Associates
   10367 West Centennial Road
   Littleton Co 80127

   If this level of appeal is denied, the provider has the right to a second level of appeal.

2. **Appeal Level Two:** The last level of appeal can be initiated by contacting the MINES case manager and requesting this appeal to be sent to the payor source for review and determination. MINES has no influence or authority regarding the timing or the time frame for the payor's response or the payor's decision.

Provider/Facility Responsibilities for Insurance and Eligibility Verification

It is the Provider/Facility's responsibility to verify eligibility and to check the exclusions that insurance plans have in their SPDs. Each of the plans that MINES represents has unique features and exclusions.

Outpatient Mental Health Treatment

Description

Outpatient Mental Health Treatment is reserved for those situations wherein a client's current symptoms are consistent with a psychological or psychiatric diagnosis, but at its current level of impairment is not of a life-threatening nature or life functioning debilitating level, such that a more restrictive level of care would be required. However, their symptoms are of such a nature that appropriate outpatient care is expected to lead to an amelioration of symptoms or in the case of chronic illnesses, management of the symptoms, as the underlying condition cannot be cured given the state of treatment for that condition at this time. This level of care includes, but is not limited to, the following treatment modalities:

- Individual therapy
- Group therapy
- Conjoint/marital therapy
- Family therapy

Criteria

The following criteria must be met for outpatient psychological/psychiatric treatment.

Admission criteria - (must meet all of the following):

1. Validated principal DSM- /ICD- (most current editions) psychological/psychiatric diagnosis.
2. There is a reasonable expectation that the client will benefit from outpatient treatment, and the client exhibits motivation as indicated by compliance with treatment recommendations.
3. Level of Stability - (must meet **all** of the following):
   a. Risk to self, others, or property is not an imminent danger.
   b. The client's support system is sufficient to sustain the performance of activities of daily living throughout the course of outpatient treatment.
   c. The client is medically stable and does not require a level of care that includes more intensive medical monitoring.
4. Degree of Impairment - (Must meet a **and** b **or** c):
   a. Client has the resources or skills necessary to maintain an adequate level of functioning in the home environment but exhibits impairments arising from a psychiatric disorder that compromises their judgment, impulse control, and/or cognitive-perceptual abilities.
   b. Social/Interpersonal/Familial - Client exhibits limited impairment in social, interpersonal, or familial functioning arising from a psychiatric disorder which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.
   c. Vocational/Educational - Client exhibits limited impairment in occupational or educational functioning arising from a psychiatric disorder which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.

Admission service components - (must meet all of the following):

1. Professional Staff:
   a. Must be licensed at the independent practice level.
   b. If unlicensed, or license eligible, must be appropriately supervised by the licensed supervisor and meet the criteria of client's specific insurance plan.

c. Services provided must be within the therapist's scope of training and licensure.

2. Complete bio/psycho/social assessment including but not limited to relevant history, previous treatment, current medical conditions including medications, substance abuse history, lethality assessment, and complete mental status exam.
3. Individualized, active treatment plan directed toward the alleviation of the impairment.
4. Development of specific, behaviorally based treatment goals that address the problems that resulted in the client seeking treatment and are regularly modified to reflect client's progress.
5. Treatment frequency based on clinical need.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors.
4. Motivation for treatment is assessed and is evaluated as having good motivation to recover with a preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client is cooperating in treatment. Motivation at this level of care is shown by engaging in sessions, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Not part of a pre-established program plan or timeframes.
7. Appearance of new problems meeting level of care guidelines.
8. Continuation of symptoms and/or behaviors that initially required treatment or have not improved and a new treatment plan has been developed.

Discharge criteria:

1. Treatment goals have been met and client is stabilized. Or there is no need for further care at that time for maintenance.
2. Client's symptoms require a more intensive level of care.
3. The client is unable to participate in treatment, is noncompliant with treatment, or client needs a higher level of care.

Intensive Outpatient Mental Health Treatment

Description

Intensive Outpatient Mental Health Treatment is reserved for those situations wherein a client's current symptoms are consistent with a psychological/psychiatric diagnosis, but at its current level of impairment is not of a life-threatening nature, such that a more restrictive level of care would be required. However, their symptoms are of such a nature that the risk of regression requiring a more restrictive level of care is likely without an intensified or more structured approach to treatment.

Criteria

The following criteria must be met in approving Intensive Outpatient Program (IOP) mental health treatment.

Admission criteria - (must meet all of the following):

1. Validated principal DSM /ICD (most current editions) psychological/psychiatric diagnosis.
2. Treatment at a lower level of care has been attempted or given serious consideration.
3. Level of Stability - (must meet **all** of the following):
    a. Risk of harm to self, others, or property is present and can be adequately managed with multiple weekly therapeutic contacts.
    b. The support system of an intensive outpatient program is needed to maintain activities of daily living.
    c. Client is medically stable and therefore does not require ongoing medical observation and care.
4. Degree of Impairment - (must meet a, **and either** b **or** c):
    a. Client has insufficient resources or skills necessary to maintain an adequate level of functioning outside of the intensive treatment plan.
    b. Social/Interpersonal - Impaired interpersonal functioning arising from acute psychiatric disorder or acute exacerbation of a chronic psychiatric condition requiring intensive intervention to resume an adequate level of functioning.
    c. Vocational/Educational - Impaired occupational, or educational functioning arising from an acute psychiatric disorder or an acute exacerbation of a chronic psychiatric condition requiring intensive treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional staff:
    a. Consultation by a psychiatrist as needed.
    b. Program managed by a certified or licensed mental health professional.
    c. Psychologists, social workers, and ancillary staff as needed.
    d. Level of skilled intervention consistent with client risk.
    e. Facility is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of the symptoms that led to the intensive treatment, within the context of an appropriately structured program of care based upon a comprehensive client assessment.
3. Services to include individual and group counseling, family therapy, educations groups, and medication management or referrals to medication management services if not provided in house.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as having fair motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating in structured treatment. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, has the ability to be independent, manages other comorbid symptoms, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less structured level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. Client's symptoms require a more intensive level of care. Lack of compliance with treatment does not necessitate a higher or more structured level of care in and of itself. The clinical symptoms are the relevant decision variables.
3. The client is unable to participate in or is noncompliant with treatment.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with appropriate referrals to multiple resources to help with baseline limitations.

Mental Health Partial Hospitalization/Day Treatment

Description

Partial hospitalization/day treatment (PHP) is for clients with serious mental health diagnoses who require coordinated, intensive, comprehensive, and multidisciplinary treatment that are not available in an outpatient or intensive outpatient setting. This level of care is designed to be more flexible and less structured or restrictive than full inpatient care. The patient's autonomy is maintained as the patient is staying outside of the treatment facility inpatient or residential unit and has access to their community resources. Partial hospitalization/day treatment (PHP) must include major diagnostic, medical, psychiatric, psychosocial, and prevocational treatment components. It is utilized by individuals who are mentally or emotionally impaired but who can maintain themselves at a minimal level of functioning and present no imminent harm to themselves or others.

Partial hospitalization/day treatment is not an automatic step-down from more intense levels of care. Discharge from inpatient care should be to the most appropriate and least restrictive level of care (See "Inpatient Criteria" for discharge criteria).

Goals of this level of care are to reduce symptoms, restore individuals to the best possible level of functioning, and prevent, to the greatest extent possible, future deterioration. The goal is not to cure underlying conditions given the state of evidenced-based treatment at this time.

Criteria

The following criteria must be met in approving partial hospitalization/day treatment as the treatment of choice for a given client.

Admission criteria - (must meet all of the following):

1. Validated principal DSM /ICD (most current editions) psychological/psychiatric diagnosis.
2. Treatment at a lower level of care has been considered or attempted and has failed or current symptom acuity precludes lower levels of care due to clinical necessity
3. Level of Stability - (all of the following must be met):
    a. Risk of harm to self, or others is present but does not meet medical necessity criteria requiring 24-hour supervision.
    b. The structure and support of the partial hospital program is necessary to maintain activities of daily living.
    c. Client is medically stable but may require occasional medical observation and care.
4. Degree of impairment - (must meet a, **and either** b **or** c):
    a. Client has insufficient or severely limited resources or skills necessary to maintain an adequate level of functioning outside of the treatment program and has impairment of one or more of the following: judgment, impulse control, and/or cognitive/perceptual abilities arising from an **acute** psychiatric disorder or an **acute** exacerbation of a **chronic** psychiatric condition.
    b. Social/Interpersonal - Impaired interpersonal functioning arising from an **acute** psychiatric disorder or an **acute** exacerbation of a **chronic** psychiatric condition requiring active treatment to resume an adequate level of functioning.

c. Vocational/Educational - Impaired occupational or educational functioning arising from an **acute** psychiatric disorder or **acute** exacerbation of a **chronic** psychiatric condition requiring active treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional Staff:
   a. Consultation by psychiatrist is available on a regular basis.
   b. Nursing staff available.
   c. Program managed by a certified or licensed mental health professional.
   d. Psychologist, social worker, or ancillary staff are available as needed.
   e. Availability of appropriate medical services.
   f. Facility is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of symptoms that were associated with the admission, within the context of a structured program of care that is based upon a comprehensive assessment.
3. Active discharge planning initiated upon admission to program.
4. The treatment is individualized and not determined by a program time frame.
5. Active family involvement is required on at least a weekly basis or more often as clinically necessary unless contraindicated.
6. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
7. Individual therapy with a licensed mental health therapist daily.
8. Family assessment and therapy when appropriate. Individual and family therapy to start within 24 hours unless clinically contraindicated.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as having partial to fair motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating in a daily structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.

11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. Client's symptoms require a more intensive level of care. The lack of compliance with treatment does not necessitate a higher level of care in and of itself.
3. The client is unable to participate in or is noncompliant with treatment.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with appropriate referrals to multiple resources to help with baseline limitations.

Short Term, Subacute Residential Mental Health Treatment

Description

Residential treatment care (RTC) is reserved for those situations wherein a client's current symptoms are such that response at a lower level of care is untenable, due either to the emergence of acute symptomology related to the severity of the disorder or a lack of response at less restrictive or structured levels of intervention, despite active participation of the client and/or their family. Client safety is of central concern. All elements of medical necessity have been met. The impairment in functioning is seen across multiple categories such as work, home and in the community.

Residential treatment is not a step-down from more intense levels of care. Discharge from inpatient care, for example, should be to the most appropriate level of care.

Goals of this level of care are to reduce symptoms (acuity, frequency, intensity, or duration as appropriate), restore individuals to a level of life functioning that is at base rate prior to the acute situation, and prevent, to the greatest extent possible, future deterioration.

There should be a reasonable expectation that client's symptoms will be stabilized and improved. A short term, subacute, residential treatment service will likely benefit the client's behaviors/symptoms. It is expected that the client will be able to return to a less intrusive level of care such as outpatient treatment once their condition has stabilized. The client no longer meets the medical necessity for this level of care. In the case of chronic illnesses (e.g., certain types of depression or PTSD, but not limited to these examples), less restrictive levels of care do not allow for the treatment structure to provide management of the symptoms that allow for a return to base rate life functioning. For a chronic illness, the underlying condition cannot be cured given the state of treatment for that condition at this time. Client is expressing a willingness to actively participate in treatment.

Current symptom acuity precludes lower levels of care.

Criteria

The following criteria must be met in approving residential care.

Admission criteria - (must meet 1 and 2, and either 3 or 4):

1. Validated principal DSM- /ICD- (most current editions) psychological/psychiatric diagnosis.
2. Treatment at a lower level of care has not been efficacious for symptom improvement based on symptom frequency, intensity, and duration determined by the clinical assessment; or if the client has not had treatment at lower levels of care there is clinical evidence to suggest that this level of care is needed to provide structure and support.
3. Level of Stability - (must meet at least **one** of the following):
    a. Significant danger to self or others exists without sufficient resources to contain risk outside of a 24-hour supervised program.
    b. The structure and support of residential treatment is necessary to maintain activities of daily living.
    c. Coexisting medical condition(s) that would complicate or interfere with the treatment.
4. Degree of Impairment - (must meet a **and either** b **or** c):

a. Client has insufficient resources or skills to maintain an adequate level of functioning outside of the residential setting and has impairment of judgment, impulse control, and/or cognitive/perceptual abilities arising from a significant psychiatric condition which may indicate the need for the continuous monitoring and intervention of a residential facility in order to stabilize or reverse the dysfunction.
b. Social/Interpersonal - Significantly impaired interpersonal functioning arising from a significant psychiatric condition which may indicate the need for residential treatment to resume an adequate level of functioning.
c. Vocational/Educational - Impaired occupational or educational functioning arising from a significant psychiatric condition which may indicate the need for active residential treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional staff:
   a. Psychiatrist assigned to, overseeing, and responsible for client care. Appropriate frequency of contact for medication management from the psychiatrist.
   b. Skilled nursing care available onsite 8 hours a day and 24-hour availability.
   c. Program managed by a certified or licensed mental health professional.
   d. Psychologist, social worker, or ancillary staff are available as needed.
   e. Availability of appropriate medical services. Suicide/homicide precautions as required.
   f. Medical assessment and physical examination within 24 hours of admission by a qualified physician.
   g. Blood and urine screens done upon admission and during stay if clinically appropriate.
   h. Facility is licensed in the state it resides.
2. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
3. Individual therapy with a licensed mental health therapist daily.
4. Group and milieu therapy at least once a day for 60-90 minutes.
5. Family therapy as appropriate, and individual therapy starting within the first 24 hours unless contraindicated.
6. The treatment is individualized and not determined by a program time frame.
7. Active discharge planning initiated at time of admission.
8. Individualized active treatment plan directed toward the alleviation of acute symptom exacerbation that resulted in the admission, within the context of a highly structured program of care that is based upon a comprehensive assessment.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as poor to fair motivation to recover. They will likely have a preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating only in this highly structured setting. Motivation at this level of care is shown by engaging in groups, cooperating

with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.

5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. The factors at a given level of care are not remitting or stabilizing and a more intensive level of care is required. Lack of compliance with treatment does not necessitate a higher level of care in and of itself.
3. The client is unable or unwilling to participate in treatment and involuntary treatment, or guardianship is not being pursued.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with appropriate referrals to multiple resources to help with baseline limitations.

Mental Health Inpatient Treatment

Description

Inpatient mental health care is for safety or medical/psychiatric/psychological stabilization. Inpatient mental health care is reserved for those situations wherein a client's current symptoms are of a life-threatening nature either to self or others (e.g., suicidal, homicidal, grave disability). Admission is initiated when care at a less restrictive or structured level of care is not feasible or cannot provide for safety and stabilization. Client safety is of central concern. All elements of medical necessity have been met. The criteria enumerated below summarize the level of care determination process:

Criteria

The following criteria must be met in approving inpatient hospitalization.

Admission criteria - (must meet all of the following):

1. Validated principal DSM /ICD- (most current editions) psychological/psychiatric diagnosis.
2. Treatment at a lower level of care has been attempted and no longer can provide for safety or lower levels of care were considered and ruled out.
3. **Level of stability** - (must meet a, b, **or** c):
    a. **Danger to self** as evidenced by (must meet i **and either** ii, iii, **or** iv):
        i. Dangerousness must be a direct product of the principal DSM or ICD (most current editions) diagnosis.
        ii. Significant life-threatening attempt to harm self within past 24 hours with continued imminent risk.
        iii. Specific plan to harm self with clear intention, high lethality, and availability of means.
        iv. Level of lethality that cannot be safely managed at a lower level of care based on clinical documentation.
    b. **Danger to others** as evidenced by (must meet i **and either** ii, iii, **or** iv):
        i. Dangerousness must be a direct product of the principal DSM or ICD (most current edition) diagnosis.
        ii. Significant life-threatening action within past 24 hours with continued imminent risk.
        iii. Specific plan with clear intention, high lethality, and availability of means.
        iv. Level of lethality that cannot be safely managed at a lower level of care based on clinical documentation.
    c. **Gravely disabled** as evidenced by (must meet i **and** ii **and either** iii **or** iv):
        i. Grave disability must be a direct product of the principal DSM or ICD (most current edition) diagnosis.
        ii. A loss of ability to perform activities of daily living due to severely impaired judgment, impulse control, or cognitive/perceptual abilities.
        iii. Acute exacerbation of a chronic psychiatric condition.
        iv. Significant decrease in functioning as measured against baseline functioning over the preceding year.
4. **Level of disability** – (must meet a **and either** b, c, **or** d):
    a. Cannot be safely managed at a lower level of care.

b. Presence of a coexisting medical condition(s) that would complicate or interfere with the treatment of the psychiatric disorder at a less intensive level of care.
c. High-risk psychiatric procedures that require intensive observation by medical personnel.
d. Acute psychotic symptoms that are severe clinical manifestations, symptoms, or complications that creates immediate risk to self or to others due to impairment in judgment, which preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and require 24-hour nursing/medical assessment, intervention, and/or monitoring.

5. **Degree of Impairment** - (must meet a, **and either** b **or** c):
   a. Client has insufficient or severely limited resources or skills necessary to maintain an adequate level of functioning outside of the inpatient setting and has impairment of one or more of the following: judgment, impulse control, and/or cognitive/perceptual abilities arising from an acute psychiatric disorder or an acute exacerbation of a chronic psychiatric condition;
   b. Social/Interpersonal - Impaired interpersonal functioning arising from an acute psychiatric disorder or an acute exacerbation of a chronic psychiatric condition requiring active treatment to resume an adequate level of functioning.
   c. Vocational/Educational - Impaired occupational or educational functioning arising from an acute psychiatric disorder or acute exacerbation of a chronic psychiatric condition requiring active treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional Staff:
   a. Psychiatrist assigned to, overseeing, and responsible for client care. A minimum of daily visits from the psychiatrist.
   b. Nursing staff available.
   c. Program managed by a certified or licensed mental health professional.
   d. Psychologist, social worker, or ancillary staff are available as needed.
   e. Availability of appropriate medical services, suicide/homicide precautions as required.
   f. Medical assessment and physical examination within 24 hours of admission.
   g. Blood and urine screens done upon admission and during if appropriate.
   h. Facility is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of acute symptoms that caused the admission, within the context of a highly structured program of care that is based upon a comprehensive assessment (to be completed at the time of admission). This level of care has no evidence-based practice that underlying conditions are cured only managed. This is similar to cardiac patients being hospitalized and have a stent put in. The underlying disease processes are not curable just managed and then the patient is discharged to a lower level of care.
3. Family assessment and therapy when appropriate. Individual and family therapy to start within 24 hours unless clinically contraindicated.
4. Active discharge planning initiated upon admission to program and includes appropriate continuing care plans.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.

4. The reasonable likelihood of a clinically significant benefit as a result of active intervention which necessitates this is level of care.
5. Motivation for treatment is assessed and is evaluated as having poor motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client lacks cooperation with treatment or is cooperating only in this highly structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
6. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
7. Continued stay is not primarily due to a lack of external supports.
8. Continued stay is not primarily for the purpose of providing a safe and structured environment.
9. Not part of a pre-established program plan or timeframes.
10. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
11. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. The factors at a given level of care are not remitting or stabilizing and an institutionalized level of care is required.
3. The client is unable to participate in treatment or is nonadherent with treatment and involuntary treatment or guardianship is not being pursued.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with appropriate referrals to multiple resources to help with baseline limitations.

Eating Disorder Treatment

Eating disorders are a subset of other mental health conditions. As a part of this subset, they must meet the same criteria for levels of care as any other diagnosis. The assessment of medical necessity for inpatient care, residential, or partial hospitalization may have some physiological variations and medical acuity considerations. However, evidence-based criteria are still relevant. Many of these clients are medically stable with their eating disorder functioning as a chronic illness. For those who are not medically stable and/or in need of more treatment structure the following levels of care and associated criteria should be considered.

"In determining a patient's initial level of care or whether a change to a different level of care is appropriate, it is important to consider the patient's overall physical condition, psychology, behaviors, and social circumstances rather than simply rely on one or more physical parameters such as weight." The APA (American Psychiatric Association) does address the difficulty of those less than 85% in gaining weight and the need for structure if the patient cannot gain weight without it. For children and adolescents, there may be a need to hospitalize them early before medical necessity criteria are met to avert potentially irreversible effects on physical growth and development. (American Psychiatric Association, (2010), Practice Guideline for the Treatment of Patients with Eating Disorders, 3rd Edition), p.13.

Cognitive functioning and impairment related to starvation symptoms may be part of the clinical picture on determining level of care and structure. It is incumbent upon the provider to identify which executive-level cognitive functions are impaired and also the weight at which cognitive function improves. This is relevant as the levels often improve before an ideal body weight is achieved in underweight patients.

Outpatient Care

Admission criteria - (must meet all of the following):

1. **Validated principal DSM /ICD -** (most current editions) psychological/psychiatric diagnosis related to Feeding and Eating Disorders.
2. **Level of Stability -** (must meet **all** of the following):
   a. Risk to self, others, or property is not an imminent danger.
   b. The client's support system is sufficient to sustain the performance of activities of daily living throughout the course of outpatient treatment.
   c. The client is medically stable and does not require a level of care that includes more intensive medical monitoring.
3. **Degree of Impairment -** (Must meet a, **and** b **or** c):
   a. Client has the resources or skills necessary to maintain an adequate level of functioning in the home environment but exhibits impairments arising from a psychiatric disorder which compromises their judgment, impulse control, and/or cognitive-perceptual abilities.
   b. Social/Interpersonal/Familial - Client exhibits limited impairment in social, interpersonal, or familial functioning arising from a psychiatric disorder which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.
   c. Vocational/Educational - Client exhibits limited impairment in occupational or educational functioning arising from a psychiatric disorder which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.

Admission service components - (must meet all of the following):

1. Professional Staff (must meet a, **or** b **and** c):
   a. Must be licensed at the independent practice level.
   b. If unlicensed, or license eligible, must be appropriately supervised by the licensed supervisor and meet criteria of specific insurance plan.
   c. Services provided must be within the therapist's scope of training and licensure.
2. Complete bio/psycho/social assessment including but not limited to relevant history, previous treatment, current medical conditions including medications, substance abuse history, lethality assessment, and complete mental status exam.
3. Nutritional planning and interventions with a registered dietitian.
4. Individualized, active treatment plan directed toward the alleviation of the impairment, or in the case of chronic illnesses, management of the symptoms, as the underlying condition cannot be cured given the state of treatment for that condition at this time, that resulted in the client seeking treatment.
5. Development of specific, behaviorally based treatment goals that address the problems that resulted in the client seeking treatment and are regularly modified to reflect client's progress.
6. Treatment frequency based on clinical need.

Continued stay criteria - (must meet all of the following):

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors.
4. Motivation for treatment is assessed and is evaluated as having good motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client is cooperating in treatment. Motivation at this level of care is shown by engaging in sessions, cooperating with the treatment plan, completing assignments, gaining the ability to eat independently, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Not part of a pre-established program plan or timeframes.
7. Appearance of new problems meeting level of care guidelines.
8. Continuation of symptoms and/or behaviors that initially required treatment or have not improved and a new treatment plan has been developed.

Discharge criteria:

1. Treatment goals have been met and client is stabilized or there is no need for further care at this time for maintenance.
2. Client's symptoms require a more intensive level of care.
3. The client is unable to participate in treatment or is noncompliant with treatment.

Intensive Outpatient Program

Criteria (must meet all of the follow):

1. **Validated principal DSM /ICD -** (most current editions) psychological/psychiatric diagnosis related to Feeding and Eating Disorders.
2. **Medical Status:** Medically stable that extensive medical monitoring is not required.

3. **Co-Occurring Disorder:** There is no severe co-occurring psychiatric or substance abuse disorder(s) that requires a higher level of care to stabilize those symptoms. If those features are present, those risks are evaluated and determined that they can be managed in this level of care. The co-occurring disorders require intensive treatment which can be handled at this level of care.
4. **Weight:** Generally, weight greater than that at which medical acuity symptoms require higher levels of care. Individuals at less than 85% of estimated healthy body weight can be treated at this level of care successfully contingent upon motivation, support, and adherence factors.
5. **Environmental Stress:** The patient has a support system that can provide support and structure but still requires treatment structure to improve symptom reduction and gain weight.
6. **Structure required for weight gain:** Requires less to no supervision during and/or after meals to ensure proper nutrition to gain or stabilize weight. Other compulsive behaviors and purging behaviors are generally self-moderated. Occasional relapses or slips are common and are not in and of themselves a criterion for higher levels of care as long as the patient is medically stable. The patient can ask for support and use coping skills to avoid or manage eating disordered behaviors.
7. **Degree of impairment -** (must meet a, **and either** b **or** c):
    a. Client has some resources or skills necessary to maintain an adequate level of functioning outside of the treatment program and has impairment of one or more of the following: judgment, impulse control, and/or cognitive/perceptual abilities arising from an **acute** psychiatric disorder or an **acute** exacerbation of a **chronic** psychiatric condition.
    b. Social/Interpersonal - Impaired interpersonal functioning arising from an **acute** psychiatric disorder or an **acute** exacerbation of a **chronic** psychiatric condition requiring active treatment to resume an adequate level of functioning.
    c. Vocational/Educational - Impaired occupational or educational functioning arising from an **acute** psychiatric disorder or **acute** exacerbation of a **chronic** psychiatric condition requiring active treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional staff:
    a. Consultation by a psychiatrist as needed.
    b. Program managed by a certified or licensed mental health professional.
    c. Psychologists, social workers, and ancillary staff as needed.
    d. Level of skilled intervention consistent with client risk.
    e. Facility is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of the symptoms that led to the intensive treatment, within the context of an appropriately structured program of care based upon a comprehensive client assessment.
3. Nutritional planning and interventions with a registered dietitian.
4. Active discharge planning initiated upon admission to program.
5. The treatment is individualized and not determined by a program time frame.
6. Services to include individual and group counseling, family therapy, educations groups, and medication management or referrals to medication management services if not provided in house.

Continued stay criteria - (must meet all of the following):

1. Conditions outlined above must be met.

2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as having fair motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating in structured treatment. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, has the ability to eat independently, manages other symptoms such as the urge to purge, binge, or restrict and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment at this time.
2. Client's symptoms require a more intensive level of care.
3. The client is unable to participate in or is noncompliant with treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with appropriate referrals to multiple resources to help with baseline limitations.

Partial Hospitalization (full-day outpatient care)

Criteria (must meet all of the follow):

1. **Validated principal DSM /ICD-** (most current editions) psychological/psychiatric diagnosis related to Feeding and Eating Disorders.
2. **Medical status:** Medically stable that extensive medical monitoring is not required.
3. **Co-occurring disorder:** There is no severe co-occurring psychiatric or substance abuse disorder(s) that requires a higher level of care to stabilize those symptoms. If those features are present, those risks

are evaluated and determined that they can be managed in this level of care. The co-occurring disorders require intensive treatment which can be handled at this level of care.

4. **Weight:** Generally, weight greater than that at which medical acuity symptoms require higher levels of care. Individuals at less than 85% of estimated healthy body weight can be treated at this level of care successfully contingent upon motivation, support, and adherence factors.
5. **Environmental stress:** The patient has a support system that can provide some support and structure but still requires daily treatment structure to improve symptom reduction and gain weight.
6. **Motivation:** Partial to fair motivation to recover although there may be preoccupation of maladaptive and intrusive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. The patient is cooperative with structured treatment.
7. **Structure required for weight gain:** Requires supervision during and/or after most meals to ensure proper nutrition to gain weight and to prevent other compulsive behaviors and purging behaviors. Occasional relapses or slips are common and are not in and of themselves a criterion for higher levels of care as long as the patient is medically stable. The patient can ask for support and use coping skills to avoid eating disordered behaviors.
8. **Degree of impairment -** (must meet a, **and either** b **or** c):
    a. Client has limited resources or skills necessary to maintain an adequate level of functioning outside of the treatment program and has impairment of one or more of the following: judgment, impulse control, and/or cognitive/perceptual abilities arising from an **acute** psychiatric disorder or an **acute** exacerbation of a **chronic** psychiatric condition.
    b. Social/Interpersonal - Impaired interpersonal functioning arising from an **acute** psychiatric disorder or an **acute** exacerbation of a **chronic** psychiatric condition requiring active treatment to resume an adequate level of functioning.
    c. Vocational/Educational - Impaired occupational or educational functioning arising from an **acute** psychiatric disorder or **acute** exacerbation of a **chronic** psychiatric condition requiring active treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional Staff:
    a. Consultation by psychiatrist is available on a regular basis.
    b. Nursing staff available.
    c. Program managed by a certified or licensed mental health professional.
    d. Psychologist, social worker, or ancillary staff are available as needed.
    e. Availability of appropriate medical services.
    f. Facility is licensed in the state it resides in.
2. Nutritional planning and interventions with a registered dietitian.
3. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
4. Individualized active treatment plan directed toward the alleviation of symptoms that were associated with the admission, within the context of a structured program of care that is based upon a comprehensive assessment.
5. Individual therapy with a licensed mental health therapist daily.

6. Active family involvement is required on at least a weekly basis or more often as clinically necessary unless contraindicated.
7. Active discharge planning initiated upon admission to program.
8. The treatment is individualized and not determined by a program time frame.
9. Individual and family therapy to be started within 24 hours as clinically appropriate. Documentation required if it is not started within 24 hours.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as having partial to fair motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating in a daily structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to eat independently, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. Client's symptoms require a more intensive level of care. Lack of compliance with treatment does not necessitate a higher level of care in and of itself.
3. The client is unable to participate in or is noncompliant with treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with appropriate referrals to multiple resources to help with baseline limitations.

Residential Treatment

Criteria (must meet all of the follow):

1. **Validated principal DSM /ICD -** (most current editions) psychological/psychiatric diagnosis related to Feeding and Eating Disorders.
2. **Medical status:** Medically stable to where intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed
3. **Co-occurring disorder:** There are no severe co-occurring psychiatric or substance abuse disorder(s) that requires a higher level of care to stabilize those symptoms. If those features are present, those risks are evaluated and determined that they can be managed in this level of care.
4. **Weight:** Generally, weight < 85% of recommended body weight or BMI of 16.5 or lower. Patients whose weight is < 85% of recommended body weight is not sufficient in and of itself as a consideration for continued stay at this level in the absence of other acute medical instability factors. If medically stable and treatment is focused on behavioral interventions related to feeding and other psychological symptoms, motivation to recover is moderate or above then consider moving to PHP or IOP depending on meeting those levels of treatment criteria.
5. **Environmental stress:** Severe family conflict or problems related to support system are impacting the patient's ability to stabilize their condition and require 24-hour care to minimize their symptom reduction.
6. **Structure required for weight gain:** Requires supervision at all meals to prevent restricting and/or requires structure to prevent other compulsive behaviors and purging behaviors. The patient can ask for support and use coping skills to avoid eating disordered behaviors.
7. **Degree of impairment -** (must meet a **and either** b **or** c):
    a. Client has insufficient resources or skills to maintain an adequate level of functioning outside of the residential setting and has impairment of judgment, impulse control, and/or cognitive/perceptual abilities arising from a significant psychiatric condition which may indicate the need for the continuous monitoring and intervention of a residential facility in order to stabilize or reverse the dysfunction.
    b. Social/Interpersonal - Significantly impaired interpersonal functioning arising from a significant psychiatric condition which may indicate the need for residential treatment to resume an adequate level of functioning.
    c. Vocational/Educational - Impaired occupational or educational functioning arising from a significant psychiatric condition which may indicate the need for active residential treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional staff:
    a. Psychiatrist assigned to, overseeing, and responsible for client care. Appropriate frequency of contact for medication management from the psychiatrist.
    b. Skilled nursing care available onsite 8 hours a day and 24-hour availability.
    c. Program managed by a certified or licensed mental health professional.
    d. Psychologist, social worker, or ancillary staff are available as needed.
    e. Availability of appropriate medical services. Suicide/homicide precautions as required.
    f. Medical assessment and physical examination within 24 hours of admission by a qualified physician.

g. Blood and urine screens done upon admission and during if appropriate.
h. Facility is licensed in the state it resides in.

2. Nutritional planning and interventions with a registered dietitian.
3. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
4. Individual therapy with a licensed mental health therapist daily.
5. Group and milieu therapy at least once a day for 60-90 minutes.
6. Family therapy as appropriate starting the first 24 hours unless contraindicated.
7. The treatment is individualized and not determined by a program time frame.
8. Active discharge planning initiated at time of admission.
9. Individualized active treatment plan directed toward the alleviation of acute symptom exacerbation that resulted in the admission, within the context of a highly structured program of care that is based upon a comprehensive assessment.
10. Individual and family therapy to be started within 24 hours as clinically appropriate. Documentation required if it is not started within 24 hours.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as poor to fair motivation to recover. They will likely have a preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating only in this highly structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to eat independently, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
12. Weight at less than 85% of recommended body weight is not sufficient for continued stay at this level in the absence of other acute medical instability factors. If medically stable and treatment is focused on

behavioral interventions related to feeding and other psychological symptoms, then consider moving to PHP or IOP depending on meeting those criteria.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. The factors at a given level of care are not stabilizing and a more intensive level of care is required. Lack of compliance with treatment does not necessitate a higher level of care in and of itself.
3. The client is noncompliant or not motivated to participate in treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with referrals to multiple resources to help with baseline limitations.

Inpatient Hospitalization

Criteria (must meet all of the following):

1. **Validated principal DSM /ICD** - (most current editions) psychological/psychiatric diagnosis related to Feeding and Eating Disorders.
2. **Level of stability** - (must meet a, b, **or** c):
   a. **Danger to self** (as evidenced by i, ii, **or** iii):
      i. Significant life-threatening attempt to harm self within past 24 hours with continued imminent risk.
      ii. Specific plan to harm self with clear intention, high lethality, and availability of means.
      iii. Level of lethality that cannot be safely managed at a lower level of care.
   b. **Danger to others** (as evidenced by i, ii **or** iii):
      i. Significant life-threatening action within past 24 hours with continued imminent risk; or,
      ii. Specific plan with clear intention, high lethality, and availability of means; or,
      iii. Level of lethality that cannot be safely managed at a lower level of care.
   c. **Gravely disabled** as evidenced by a loss of ability to perform activities of daily living due to severely impaired judgment, impulse control, or cognitive/perceptual abilities.
3. **Medical status:** There are biomedical complications that need 24-hour care, that **might** include the following:
   a. **Adults**:
      i. BMI less than 15
      ii. Heart rate (pulse): < 40 bpm
      iii. Greater than 10% decrease in body weight in last 30 days
      iv. Blood pressure: < 90/60 mm Hg
      v. Glucose: < 60 mg/dL
      vi. Potassium: < 3 mEq/L

vii. Sodium: 125 meq/l
viii. Magnesium/phosphate: below normal range
ix. Temperature: < 97.0° F
x. Dehydration
xi. Hepatic, renal, or cardiovascular organ compromise requiring treatment
xii. Body temperature: < 96° F or cold blue extremities
xiii. Poorly controlled diabetes

b. **Children and adolescents**:
i. Heart rate near 40 bpm
ii. Orthostatic hypotension (with an increase in pulse of > 20 bpm or a drop in blood pressure of > 10–20 mm Hg/minute from supine to standing
iii. Blood pressure < 80/50 mm Hg
iv. Sodium 130 meq/l
v. Hypokalemia, hypophosphatemia, or hypomagnesemia
vi. Magnesium/phosphate: below normal range
vii. Body temperature: < 96° F or cold blue extremities

4. **Weight:** generally, weight < 85% of recommended body weight, and typically significantly less, and has resulted in acute medical complications or acute weight decline with food refusal resulting in acute medical complications. Under either scenario, medical intervention is necessary to stabilize the patient.
5. **Structure required for weight gain:** Need for supervision during and after all meals and in bathrooms and inability to control purging behaviors that are persistent and disabling. Requires supervision to interrupt the compulsory behaviors such as purging, binging, use of laxatives, excessive exercising, etc. that have caused significant biomedical complications that require imperative medical treatment.
6. **Disabling symptomatology:** Severe disabling or worsening of symptoms of eating disorder behaviors:
   a. Compensatory behaviors such as binging, purging, laxative abuse, excessive exercise occurs multiple times a day and have caused significant physiological complications that require urgent medical treatment; or,
   b. The above behaviors have failed to respond to treatment.
7. If PHP or IOP is contraindicated, documentation of the rationale supporting the contraindication is required.

Admission Service Components - (must meet all of the following):

1. Professional Staff:
   a. Psychiatrist assigned to, overseeing, and responsible for client care. A minimum of daily visits from the psychiatrist.
   b. Nursing staff available.
   c. Program managed by a certified or licensed mental health professional.
   d. Psychologist, social worker, or ancillary staff are available as needed.
   e. Availability of appropriate medical services, suicide/homicide precautions as required.
   f. Medical assessment and physical examination within 24 hours of admission.
   g. Blood and urine screens done upon admission and during if appropriate.
   h. Facility is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of acute symptoms that caused the admission, within the context of a highly structured program of care that is based upon a comprehensive

assessment (to be completed at the time of admission). This level of care has no evidence-based practice that underlying conditions are cured, only managed. This is similar to cardiac patients being hospitalized and have a stent put in. The underlying disease processes are not curable just managed and then the patient is discharged to a lower level of care.

3. Family assessment and therapy when appropriate. Individual and family therapy to start within 24 hours unless clinically contraindicated.
4. Nutritional planning and interventions with a registered dietitian.
5. Active discharge planning initiated upon admission to program and includes appropriate continuing care plans.
6. The treatment is individualized and not determined by a program time frame.
7. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
8. Individual therapy with a licensed mental health therapist daily.
9. Group and milieu therapy.
10. Individual and family therapy to be started within 24 hours as clinically appropriate. Documentation required if it is not started within 24 hours.

Continued Stay Criteria (must meet all criteria):

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. The reasonable likelihood of a clinically significant benefit as a result of active intervention which necessitates this is level of care.
5. Motivation for treatment is assessed and is evaluated as having poor motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client lacks cooperation with treatment or is cooperating only in this highly structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to eat independently, and other qualities of treatment engagement.
6. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
7. Continued stay is not primarily due to a lack of external supports.
8. Continued stay is not primarily for the purpose of providing a safe and structured environment.
9. Not part of a pre-established program plan or timeframes.
10. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
11. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
12. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.

13. Weight at less than 85% body weight is not sufficient for continued stay at this level in the absence of other acute medical instability factors. If medically stable and treatment is focused on behavioral interventions related to feeding and other psychological symptoms, then consider moving to PHP or IOP contingent upon meeting those criteria.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. The factors at a given level of care are not remitting or stabilizing and an institutionalized level of care is required. Lack of compliance with treatment does not necessitate a higher level of care in and of itself.
3. The client is noncompliant or not motivated to participate in treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with referrals to multiple resources to help with baseline limitations.

Introduction to Substance Use Disorder (Sud) Treatment

Professionally, one would think that a separate introduction to Substance Use Disorder (SUD) would not be needed in behavioral health treatment. It is reasonable to assume that evidence-based practice and innovation over the last 60 years would be comparable across both mental health and substance use treatment. It is our opinion based on the evidence and practice patterns that this is not the case. In SUD treatment, there still exists programmed lengths of stay at the highest levels with no evidence for the overall effectiveness of those programmed lengths of stay despite contributions by ASAM and other professional groups. There are still programs working "step one" at inpatient and residential levels of care rather than implementing cognitive-behavioral techniques related to relapse and adherence. Step work should be completed in AA groups or other support groups.

The field has progressed with medically assisted treatment programs, cognitive-behavioral interventions for relapse and adherence, the use of naltrexone and other antagonists. It is important for all of us to move SUD treatment forward and not stay entrenched in traditional ways of doing treatment despite evidence to the contrary regarding the lack of effectiveness of those programs. The mental health side of the equation would still be doing trephining, insulin shock treatment, and lobotomies if one used tradition and "how we used to do it" arguments.

MINES does consider the ASAM criteria. The ASAM criteria are used along with other evidence-based criteria to determine what is the best level of care for the individual. The intention of the ASAM criteria is to further inform the professionals involved in determining the client's treatment journey. The ASAM criteria mirror the assumptions of MINES UR criteria in many ways (multidimensional assessment, clinically driven and outcome-driven treatment, variable length of service, broad and flexible continuum of care, adolescent-specific needs, clarifying the goals of treatment, moving away from using previous "treatment failure" as an admission prerequisite, interdisciplinary, team approach to care, role of the physician, focus on treatment outcomes, informed consent, and medical necessity. ASAM noted that there have not been validity or reliability studies done with its matrices (using the dimensions and ratings, ASAM, 2013, p.70). This is a cautionary note to guide clinical decisions based on clinical and scientific evidence.

Furthermore, as most SUDs are chronic in nature (parallels with diabetes, cardiac disease, asthma, or hypertension) and life-time management of those chronic processes and SUDs becomes the focus, not curing an addiction process for which there is no known cure at this time. "Current outcome research in addictions treatment has not yet provided a scientific basis for determining precise lengths of stay for optimum results: (ASAM, 2013, p.4). Length of treatment does not mean longer stays in restricted levels of care, it means individualized care at the levels needed to learn the skills for maintenance and relapse prevention over a lifetime. As is well established in learning theory, spaced learning with repetition overtime generally has better results than mass learning in condensed timeframes. This is a strong argument for continued aftercare, ongoing outpatient treatment, or community support organizations.

ASAM criteria have as a primary goal to place the client/patient at the most appropriate level of care both clinically and financially. "This is defined as the level which is the least intensive while still meeting treatment objectives and providing safety and security for the patient" (ASAM, 2013, p.4).

As noted in the ASAM criteria and others, adolescents may require different considerations related to developmental psychology considerations such as cognition (problem-solving) and cognitive development,

emotional, social, and moral development, behavior patterns, impulse control and safety, family systems issues, parenting skills, and peer group considerations among other factors.

Outpatient Substance Use Disorder Treatment

Description

Outpatient Substance Use Disorder Treatment is reserved for those situations wherein a client's current symptoms are consistent with a substance use disorder diagnosis, but at its current level of impairment is not of a life-threatening nature, such that a more restrictive level of care would be required. However, their symptoms are of such a nature that appropriate outpatient care is expected to lead to amelioration and/or management of symptoms and the addictive process. This level of care includes, but is not limited to, the following treatment modalities:

- Individual therapy
- Group therapy
- Conjoint/marital therapy
- Family therapy

Criteria

The following criteria must be met for outpatient substance use disorder treatment.

Admission criteria - (must meet all of the following):

1. Validated principal DSM /ICD (most current editions) psychological/psychiatric diagnosis related to Substance-related and Addictive Disorders.
2. There is a reasonable expectation that the client will benefit from outpatient treatment, and the client exhibits motivation as indicated by compliance with treatment recommendations.
3. Level of Stability - (must meet **all** of the following):
   a. Risk of harm to self, others, or property is not an imminent danger.
   b. The client's support system is sufficient to sustain the performance of activities of daily living throughout the course of outpatient treatment.
   c. The client is medically stable and does not require a level of care that includes more intensive medical monitoring.
4. Degree of Impairment - (Must meet a **and** b **or** c):
   a. Client has the resources or skills necessary to maintain an adequate level of functioning in the home environment but exhibits impairments arising from a substance abuse disorder that compromises their judgment, impulse control, and/or cognitive-perceptual abilities.
   b. Social/Interpersonal/Familial - Client exhibits limited impairment in social, interpersonal, or familial functioning arising from a substance abuse disorder which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.
   c. Vocational/Educational - Client exhibits limited impairment in occupational or educational functioning arising from a substance abuse disorder which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.

Admission service components - (must meet all of the following):

1. Professional Staff:
   a. Must be licensed at the independent practice level.
   b. If unlicensed, or license eligible, must be appropriately supervised by the licensed supervisor and meet criteria of the client's specific insurance plan.

c. Services provided must be within the therapist's scope of training and licensure.
d. Educated and experienced working with substance abuse and mental health disorders to be able to evaluate and engage client in their sobriety.

2. Complete bio/psycho/social assessment including, but not limited to, relevant history, previous treatment, current medical conditions including medications, substance abuse history, lethality assessment, and complete mental status exam.
3. Individualized, active treatment plan directed toward the alleviation of the impairment that resulted in the client seeking treatment or in the case of chronic illnesses, management of the symptoms, as the underlying condition cannot be cured given the state of treatment for that condition at this time, that resulted in the client seeking treatment.
4. Development of specific, behaviorally based treatment goals that address the problems that resulted in the client seeking treatment and are regularly modified to reflect client's progress.
5. Treatment frequency based on clinical need.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors.
4. Motivation for treatment is assessed and is evaluated as having good motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client is cooperating in treatment. Motivation at this level of care is shown by engaging in sessions, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Not part of a pre-established program plan or timeframes.
7. Appearance of new problems meeting level of care guidelines.
8. Continuation of symptoms and/or behaviors that initially required treatment or have not improved and a new treatment plan has been developed.

Discharge criteria:

1. Treatment goals have been met and client is stabilized. Or there is no need for further care at that time for maintenance.
2. Client's symptoms require a more intensive level of care.
3. The client is unable to participate in treatment, is noncompliant with treatment, or client needs a higher level of care.

Medication Assisted Treatment (MAT) Of Opioid Dependence

Medication Assisted Treatment (MAT) is an outpatient designation. Under mental health parity, it is not managed except in a disease management program or as part of extended aftercare for an inpatient treatment episode under the complex case management protocol.

MAT utilizes pharmacological interventions to assist clients in reducing cravings and maintaining their dependence in a controlled manner until they can be stepped down on their medication dosages and adhere to a nondependent lifestyle as part of managing their chronic condition.

Providers should follow clinical best practices while treating clients under these protocols.

Sober Living

(Most plans do not cover this service, call the third-party administrator for verification)

Sober living is used when returning home has relapse risks associated with it such as a family member or roommate who is actively addicted and the patient is at risk for relapse. It often is not a covered benefit by most of our payors. In addition, it needs to be a separate facility from an inpatient/residential facility.

Substance Use - Outpatient Detoxification

Description

Outpatient detoxification is reserved for those situations wherein a client's current symptoms are not of an imminent life-threatening nature and can be managed in an office or setting other than a medical inpatient or residential setting. Admission is initiated when care at a less restrictive level of care is not feasible. Client safety is of central concern. The client does not require medical monitoring on a 24 hour a day basis. The criteria enumerated below summarize the level of care determination process.

Criteria

The following criteria must be met in approving outpatient detoxification.

Admission criteria - (must meet all of the following):

1. Validated principal DSM-/ICD- (most current editions) psychological/psychiatric diagnosis related to Substance-related and Addictive Disorders.
2. Level of Stability (All of the following must be met):
    a. Risk of harm to self, others, and property is not serious enough to require 24-hour psychiatric or medical supervision (cf. "Utilization Review - Levels of Care - Psychiatric Inpatient").
    b. Client's ability to engage in activities of daily living is compromised by withdrawal symptoms from substances.
    c. Client's medical status (vital signs and neurological functions) is altered by withdrawal syndrome, but the changes do not require constant medical supervision. Such symptoms may include:
        i. Alcohol and Sedative/Hypnotic withdrawal - agitation, anxiety, insomnia, tremor, sweating, diarrhea, headache, nausea, and vomiting.

ii. Opiate Withdrawal – irritability, lack of appetite, sweating, diarrhea, dilated pupils, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, yawning, and restlessness.
iii. Other substances such as marijuana, stimulants, and others can be managed at this level of care due to the acuity of withdrawal symptoms.

3. Degree of Impairment (must meet all):
   a. Client is severely limited in their ability to maintain an adequate level of functioning outside of the treatment program and has impairment from withdrawal syndrome which requires regular monitoring in order to stabilize the client's condition.
   b. The symptoms are causing significant clinical distress.
   c. There is clinical evidence to suggest that the client has a supportive living situation and family/friends where the client can be successful at outpatient withdrawal management.

Admission service components - (must meet all of the following):

1. Professional staff:
   a. Program managed by a certified or licensed mental health professional.
   b. Medical consultation and nursing staff available as needed.
   c. Level of skilled intervention consistent with client risk.
   d. Facility or Practitioner is licensed in the state the services are provided in.
   e. Evidenced-based interventions are utilized.
   f. Affiliations with other community resources specializing in substance abuse and mental health to provide support while monitoring for detox.
2. Individualized active treatment plan directed toward the alleviation of symptoms of impairment, within the context of an individualized program of care. This plan is not based on a pre-established program plan or timeframe.
3. Periodic monitoring of vital signs by medical or nursing staff.
4. Active family involvement is expected regarding treatment planning and therapy unless clinically contraindicated. Compliance regarding state and federal laws regarding such involvement is required.
5. Active discharge planning that is initiated at the time of admission and is based upon a comprehensive assessment.
6. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the patient’s part to maintain sobriety.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care. The patient is still not stabilized so that the patient can safely and effectively be treated at a less restrictive level of care.
3. Treatment is likely to stabilize the symptoms/behaviors.
4. Motivation for treatment is assessed and is evaluated as having good motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client is cooperating in treatment. Motivation at this level of care is shown by engaging in sessions, cooperating with the treatment plan, completing assignments, gaining the ability to eat independently, and other qualities of treatment engagement.

5. The family is involved to the best of their ability in treatment planning and discharge planning unless there are clinical contraindications.
6. Not part of a pre-established program plan or timeframes.
7. Appearance of new problems meeting level of care guidelines.
8. Continuation of symptoms and/or behaviors that initially required treatment or have not improved and a new treatment plan has been developed.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.

Discharge criteria:

1. Treatment goals have been met and patient is stabilized, and less intensive levels of care can be utilized, or the patient no longer requires detoxification treatment.
2. The factors at a given level of care are not remitting or stabilizing and a more intensive medical detoxification is required.
3. The client is unable to participate in treatment or is noncompliant with treatment. Lack of compliance with treatment does not necessitate a higher level of care in and of itself.

Substance Use - Intensive Outpatient Treatment

Description

Intensive Outpatient (IOP) Treatment is reserved for those situations wherein a client's current symptoms are consistent with a diagnosis of substance use and/or substance dependence but is not at its current level of symptomatology of an imminent life-threatening nature yet require more structure and frequency of clinical contact. The criteria enumerated below summarize the level of care determination process.

Criteria

The following criteria must be met in approving intensive outpatient substance use treatment.

Admission criteria - (must meet all of the following):

1. Validated principal DSM-/ICD- (most current editions) psychological/psychiatric diagnosis related to Substance-related and Addictive Disorders.
2. Treatment at a lower level of care has been given serious consideration or has not provided the structure needed for symptom improvement based on symptom frequency, intensity, and duration determined by the clinical assessment.
3. Level of Stability - (must meet all of the following):
    a. Risk of harm to self, others, or property is present and can be adequately managed with multiple weekly therapeutic contacts. There is no severe co-occurring psychiatric disorder that requires a higher level of care to stabilize those symptoms. If those features are present, those risks are evaluated and determined that they can be managed in this level of care. The co-occurring disorders require intensive treatment which can be handled at this level of care. (cf. "Utilization Review - Levels of Care - Psychiatric Inpatient").
    b. The support system of an intensive outpatient program is needed to maintain and support sobriety. The client has an unsupportive environment that requires near-daily structure to help the client utilize already established coping skills or require the structured program to gain the coping skills to manage in their unsupportive environment.
    c. Client is medically stable and therefore does not require ongoing medical observation and care. There is clinical evidence to suggest that this client is medically stable from severe withdrawal symptoms OR there are minimal risks of severe withdrawal symptoms that would require ongoing medical observation and care.
    d. If there are any biomedical conditions, they are stable or not distracting.
4. Degree of Impairment - (must meet a, **and either** b **or** c):
    a. Client is limited in their ability to maintain sobriety and an adequate level of functioning outside of the treatment program arising from chronic substance dependence or substance abuse which requires an individualized, structured program with a higher frequency of clinical contact and need for structure than occurs in outpatient treatment. There is clinical evidence to suggest that the client has a higher risk for relapse potential and requires this structured environment in order to monitor and support to manage relapse potential.
    b. Social/Interpersonal - Impaired interpersonal functioning arising from acute substance use disorder or acute exacerbation of a chronic substance use disorder requiring intensive intervention to resume an adequate level of functioning.

c. Vocational/Educational - Impaired occupational or educational functioning arising from an acute substance use disorder or acute exacerbation of a chronic substance use disorder requiring intensive treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional staff:
   a. Consultation by a psychiatrist and medical doctor as needed. (ASAM certification and special skills in substance abuse treatment are recommended, not required).
   b. Program managed by a certified or licensed mental health professional.
   c. Psychologists, social workers, nurses, CACs, and ancillary staff as needed.
   d. Level of skilled intervention consistent with client risk.
   e. Facility/Program is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of the symptoms of impairment that led to program enrollment, within the context of a highly structured program of care based upon a comprehensive client assessment. This plan is not based on a pre-established program plan or timeframes.
3. Active discharge planning initiated upon admission to program.
4. Services to include individual and group counseling, family therapy, educations groups, and medication management or referrals to medication management services if not provided in house.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as having fair motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating in structured treatment. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, has the ability to be independent, manages other comorbid symptoms, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment at this time.
2. Client's symptoms require a more intensive level of care.
3. The client is unable to participate in or is noncompliant with treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with referrals to multiple resources to help with baseline limitations.

Substance Use - Partial Hospitalization/Day Treatment

Description

Partial Hospitalization/Day treatment (PHP) for Substance Abuse is an alternative care setting for persons with substance use-related disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment not available in an outpatient or intensive outpatient setting. This level of care is designed to be more flexible and less structured than inpatient or residential care. PHP includes a range of structured therapeutic, psychological, and psychiatric services, with the purpose of assisting the client in acquiring the behavioral, social, and psychological skills necessary to continue managing the substance use disorder at a lower level of care.

This level of care is utilized when a client's current symptoms are such that a positive treatment response at a lower level of care is untenable, due either to the severity of the disorder or prior failure at less structured levels of treatment, despite active participation of the client and their family (where applicable).

The patient is housed either at home or in a sober living situation.

Partial hospitalization/day treatment is not an automatic step-down from more structured, intense levels of care. Discharge from inpatient care should be to the most appropriate level of care.

Criteria

The following criteria must be met in approving partial hospitalization/day treatment.

Admission criteria - (must meet all of the following):

1. Validated principal DSM-/ICD- (most current editions) psychological/psychiatric diagnosis related to Substance-related and Addictive Disorders.
2. Treatment at lower levels of care has not provided the necessary support and skills and requires more structure environment OR if the client has not had prior treatment at lower levels of care, there is clinical evidence to suggest that this type of structured environment is required.
3. Level of Stability - (all of the following must be met):
    a. The degree of risk of harm to self, others, and/or property related to the substance use disorder or mental health disorder is present but not serious enough to require 24-hour supervision. There is clinical evidence to suggest that these risks are rated as mild to moderate severity.
    b. The structure and support of the partial hospital program is necessary to maintain activities of daily living. There is clinical evidence to suggest that without this near-daily structured level of care that the client poses a significant relapse potential.
    c. There is clinical evidence to suggest that this client is medically stable from severe withdrawal symptoms OR there are moderate risks of severe withdrawal symptoms that would require ongoing medical observation and care.
    d. Any biomedical conditions are stable or not distracting.
4. Degree of Impairment - (must meet a **and either** b, c, **or** d):
    a. Client has insufficient or severely limited resources or skills necessary to maintain an adequate level of functioning outside of the treatment program and has an increased degree of impairment of one or more of the following relative to the patient's base rate of impairment due to their chronic

illness: judgment, impulse control, and/or cognitive/perceptual abilities arising from an acute substance use disorder or an acute exacerbation of a chronic substance use condition or related co-morbid psychological/psychiatric condition.

b. Social/Interpersonal - Impaired interpersonal functioning arising from an acute substance use disorder or an acute exacerbation of a chronic substance use condition or related co-morbid psychological/psychiatric condition requiring active treatment to resume an adequate level of functioning.
c. Vocational/Educational - Impaired occupational or educational functioning arising from an acute substance use disorder or an acute exacerbation of a chronic substance use condition or related co-morbid psychological/psychiatric condition requiring active treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional Staff:
   a. Consultation by psychiatrist is available on a regular basis.
   b. Nursing staff available.
   c. Program managed by a certified or licensed mental health professional.
   d. Psychologist, social worker, or ancillary staff are available as needed.
   e. Availability of appropriate medical services.
   f. Facility is licensed in the state it resides in.
2. Individualized active treatment plan directed toward the alleviation of symptoms that were associated with the admission, within the context of a structured program of care that is based upon a comprehensive assessment.
3. Active discharge planning initiated upon admission to program.
4. The treatment is individualized and not determined by a program time frame.
5. Active family involvement is required on at least a weekly basis or more often as clinically necessary unless contraindicated.
6. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
7. Individual therapy with a licensed mental health therapist daily.
8. The program is individualized and not part of a predetermined treatment plan (e.g., 28 days for everyone regardless of patient need).

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as having partial to fair motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating in a daily structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.

6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.
11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge Criteria:

1. Treatment goals have been met and client is stabilized, and less intensive levels of care can be utilized, or the client no longer requires treatment.
2. Client's symptoms require a more intensive or structured level of care. However, noncompliance with care per se does not necessarily warrant more structured care depending on the assessment of the basis for the patient's noncompliance.
3. The client is unable to participate in or is noncompliant with treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with referrals to multiple resources to help with baseline limitations.

Substance Use Disorder - Residential Treatment

Description

Residential care is reserved for those situations wherein a client's current symptoms are such that treatment at a lower level of care is untenable, due either to the severity of the disorder or failure at less structured levels of intervention, despite active participation of the client and/or their family. In addition, the client does not require 24/7 nursing care or physician availability to safely treat the client. Client safety is of central concern.

Criteria

The following criteria must be met in approving residential care.

Admission criteria - (must meet 1 and 2, and either 3 or 4):

1. Validated principal DSM-/ICD- (most current editions) diagnosis of substance use disorder.
2. Treatment at lower levels of care has not provided the necessary support or skills and requires more structured environment **or** if the client has not had prior treatment a lower level of care, there is clinical evidence to suggest that this type of structured environment is required.
3. Level of Stability - (must meet at least one of the following):
    a. The client may present with severe mental health instability symptoms such as danger to self, others, or psychosis which may be related to intoxication or withdrawal or to a co-occurring mental health condition. The client requires this level of care to monitor these risks to self, other, or psychosis and evaluate if a co-occurring mental health condition or a product of substance withdrawal.
    b. Coexisting medical condition(s) that would complicate or interfere with the treatment of the psychoactive substance disorder at a less structured level of care.
4. Degree of Impairment (must meet a **and** b **and either** c **or** d):
    a. Client has insufficient psychological resources or skills to maintain an adequate level of functioning outside of the residential setting and has significant impairment of judgment, impulse control, and/or cognitive/perceptual abilities arising from a chronic substance dependence which may indicate the need for the continuous monitoring and intervention of a residential facility in order to stabilize. If client has reached maximal medical improvement, fails to engage in treatment, has demonstrated a lack of motivation to engage in treatment, and/or has failed treatment repeatedly due to noncompliance, only medically necessary levels of care will be authorized such as detox or outpatient/intensive outpatient.
    b. There is clinical evidence to suggest that the client's living environment is unsupportive in the sense that the environment can lead the client to continued use or relapse without this structured environment if left to complete detox in an outpatient setting.
    c. Social/Interpersonal - Significantly impaired interpersonal functioning arising from a significant psychiatric condition which may indicate the need for residential treatment to resume an adequate level of functioning.
    d. Vocational/Educational - Impaired occupational or educational functioning arising from a significant psychiatric condition which may indicate the need for active residential treatment to resume an adequate level of functioning.

Admission service components - (must meet all of the following):

1. Professional staff:

a. Medical doctor (ASAM certification and special skills in substance abuse treatment are recommended, not required.)
b. Skilled nursing care available onsite 8 hours a day and 24-hour availability.
c. Psychiatrist assigned to, overseeing, and responsible for client care. Appropriate frequency of contact for medication management from the psychiatrist.
d. Program managed by a certified or licensed mental health professional.
e. Psychologists, social workers, and ancillary staff available when clinically indicated.
f. Medical services as required.
a. Medical assessment and physical examination within 24 hours of admission by a qualified physician.
b. Suicide/homicide precautions as required.
g. Blood and urine screens done upon admission and during if appropriate.
h. Facility is licensed in the state in which it resides.

2. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated, in individual, group, and family contexts.
3. Individual therapy with a licensed mental health therapist daily.
4. Group and milieu therapy at least once a day for 60-90 minutes.
5. Family therapy as appropriate starting the first 24 hours unless contraindicated.
6. Active discharge planning initiated at time of admission.
7. The treatment is individualized and not determined by a program time frame.
8. Individualized active treatment plan directed toward the alleviation of impairment that caused the admission, within the context of a highly structured program of care that is based upon a comprehensive assessment.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. Motivation for treatment is assessed and is evaluated as poor to fair motivation to recover. They will likely have a preoccupation with maladaptive, intrusive, and repetitive thoughts. These thoughts are typically present at all levels of care to varying degrees and do not in and of themselves diminish with higher levels of care. It is determined with documentation that the client is cooperating only in this highly structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
5. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
6. Continued stay is not primarily due to a lack of external supports.
7. Continued stay is not primarily for the purpose of providing a safe and structured environment.
8. Not part of a pre-established program plan or timeframes.
9. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
10. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time.

11. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and patient is stabilized, and less structured levels of care can be utilized, or the patient no longer requires treatment.
2. The factors at a given level of care are not remitting or stabilizing and a more structured level of care is required.
3. The client is unable to participate in or is noncompliant with treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.
4. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.
5. The patient requires medical/surgical treatment.
6. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with referrals to multiple resources to help with baseline limitations.

Substance use - Medical Detoxification

Description

Inpatient and Residential medical detoxification is reserved for those situations wherein a client's current symptoms are of an imminent life-threatening nature. Admission is initiated when care at a less structured level of care is not feasible. Client safety is of central concern. The criteria enumerated below summarize the level of care determination process.

Criteria

The following criteria must be met in approving inpatient substance use detoxification.

Admission criteria - (must meet all of the following):

1. Validated DSM or ICD (most current edition of either/both) psychological/psychiatric diagnosis related to Substance-related and Addictive Disorders where there is a psychoactive substance dependence and/or acute intoxication or withdrawal.
2. The pattern of alcohol and/or benzodiazepines and/opiates is of such severity that it will likely result in a severe withdrawal syndrome with acute medical complications in the immediate future requiring acute medical and nursing management.
3. Level of Stability - (must meet a **or** b **or** c):
    a. Significant medical complications resulting from continuation or discontinuation of substance use, such as:
        i. Abnormal vital signs, such as:
            - BP > 200/90

- Pulse > 120
- Temp. > 38.5°C or 101.3°F
- Respiratory distress

ii. Clinical evidence of acute intoxication with complications (e.g., combative, psychotic, etc.).
iii. Clinical or laboratory evidence of GI bleeding.
iv. Clinical or laboratory evidence of significant liver dysfunction.
v. Delirium tremens or seizures.
vi. Diaphoresis, excessive sweating.
vii. Organic Brain Syndrome secondary to substance dependence and does not require emergency medical admission.
viii. Imminent/probable severe withdrawal symptoms that produce medical complications.

b. Prior history of seizures or complicated withdrawal from alcohol/drugs and a high likelihood of reoccurrence.
c. Inability to evaluate client due to extreme toxicity - Client must be held in ER or similar medical setting until mental status clears sufficiently to evaluate prior to admission.
d. If the client presents with severe mental health instability symptoms such as danger to self, others, or psychosis which may be related to intoxication, withdrawal, or to an underlying mental health condition. The client requires this level of care to monitor these risks to self, others, or psychosis as well as monitored medically for severe withdrawal symptoms. If the client presents with the comorbidity of severe mental health safety risks as well as withdrawal medical monitoring, the facility must be equipped to manage such acuity symptoms.

4. Degree of Impairment (must meet **either** a **or** b):
    a. Client is unable to function safely outside of hospital setting without intensive medical supervision due to medical complications arising from continued/discontinued substance use.
    b. There is clinical evidence to suggest that the client's living environment is unsupportive in the sense that the environment can lead the client to continued use or relapse without this structured environment if left to complete detox in an outpatient setting.

Admission service components - (must meet all of the following):

1. Professional staff:
    a. Medical doctor. (ASAM certification and special skills in substance abuse treatment are recommended, not required.)
    b. Psychiatrist assigned to, overseeing, and responsible for client care. A minimum of daily visits from the physician.
    c. Psychologists, social workers, nurses, and ancillary staff available when clinically indicated.
    d. Medical services as required. Availability of appropriate medical services, suicide/homicide precautions as required.
    e. 24-hour nursing care for detoxification.
    f. Medical assessment and physical examination within 24 hours of admission.
    g. Blood and urine screens done upon admission and during if appropriate.
    h. Facility is licensed in the state it resides in.
2. Active discharge planning initiated at time of admission and includes appropriate continuing care plans.

3. Individualized active treatment plan directed toward the alleviation of impairment that caused the admission, within the context of a highly structured program of care that is based upon a comprehensive assessment.
4. Family assessment and therapy when appropriate.
5. Individual and family therapy to start within 24 hours unless clinically contraindicated.
6. The treatment is individualized and not determined by a program time frame.
7. Client receiving appropriate therapeutic and psychoeducational interventions as clinically indicated in individual, group, and family contexts.
8. Individual therapy with a licensed mental health therapist daily.
9. Group and milieu therapy.

Continued stay criteria:

1. Conditions outlined above must be met.
2. Client making progress toward goals and cooperating with the plan of care.
3. Treatment is likely to stabilize the symptoms/behaviors that required admission.
4. The reasonable likelihood of a clinically significant benefit as a result of active intervention which necessitates this is level of care.
5. Motivation for treatment is assessed and is evaluated as having poor motivation to recover with preoccupation with maladaptive, intrusive, and repetitive thoughts. It is determined with documentation that the client lacks cooperation with treatment or is cooperating only in this highly structured setting. Motivation at this level of care is shown by engaging in groups, cooperating with the treatment plan, completing assignments, gaining the ability to be independent, and other qualities of treatment engagement.
6. Family therapy is being completed (unless there are contraindications for including family) and is making progress toward goals and cooperating with the plan of care.
7. Continued stay is not primarily due to a lack of external supports.
8. Continued stay is not primarily for the purpose of providing a safe and structured environment.
9. Not part of a pre-established program plan or timeframes.
10. Active discharge planning is in process but not adequately in place to sustain the client in a less restrictive level of care.
11. In the case of chronic illnesses, management of the symptoms expected to return to baseline, as the underlying condition cannot be cured given the state of treatment for that condition at this time. For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan must include clear interventions to address nonadherence and relapse. There must be a goal on the client's part to maintain stability.

Discharge criteria:

1. Treatment goals have been met and patient is stabilized, and less intensive levels of care can be utilized, or the patient no longer requires treatment. An example is when the patient is medically stable and can continue the detoxification taper at a lower level of care.
2. The factors at a given level of care are not remitting or stabilizing and a more intensive level of care is required.
3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
4. The patient requires medical/surgical treatment.
5. The client is unable to participate in or is noncompliant with treatment. Lack of compliance or motivation to participate in treatment only necessitates higher levels of care or more structure when the patient

meets medical necessity criteria for acute stabilization. Medical patients and behavioral health patients have the right to not comply with treatment and are best managed at lower levels of care with the caveat they are not in imminent danger to self, others, or are gravely disabled.

6. There is clinical evidence to suggest that the client is at their baseline functioning and might meet some of the above continued stay criteria but will not improve in their symptomology. It is important to discharge to an appropriate level of care with referrals to multiple resources to help with baseline limitations.

Utilization Review Process Steps for Any Level of Care

See Facility Handbook for more information.