



CIGNA STANDARDS AND GUIDELINES/MEDICAL NECESSITY CRITERIA

**For Treatment of Mental Health and
Substance Use Disorders**

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Foreword

Over the last several years, with the passage of The Federal Mental Health Parity and Addiction Equity Act in 2008 and The Patient Protection and Affordable Care Act in 2010, the health care industry has evolved and increased in complexity. There is increased benefit coverage for people with mental health and substance use conditions, and these new laws have brought about changes in the way health care coverage is managed. As a result, some of the barriers that individuals have faced in obtaining the proper diagnosis and essential treatment for their condition have been addressed; however, we continue to be faced with a shortage of mental health and substance use disorder services and clinicians in many areas of the country. And, despite Americans having a more sophisticated understanding of mental illness, along with an increased awareness through exposure on television and in the media, studies show that there is persistent social stigma attached to people with mental illness and substance use disorders.

With over 150 million Americans covered under employer-based insurance, and millions more now covered through the state and federal exchanges, it is essential that we all work together to take advantage of the advances and opportunities brought by these new regulations. We all share the desire to see every individual receive the best care possible. In doing so, we have the responsibility to collaborate with each other to leverage each individual's health care benefits and to deliver the most effective care in the most appropriate setting at the right time.

Several key areas are necessary to consider as we engage in a cooperative and inclusive dialogue, including variations in standards of care across the country and health care disparities for people with mental health and substance use disorders. Also there are still significant gaps in service between mental health clinicians and general medical clinicians, and current regulations impede our ability to fully share important clinical information with other treating clinicians. This is important not only as we attempt to provide an integrated and holistic health care experience for individuals, but this also perpetuates the stigma associated with behavioral health and substance use disorders.

With all of the complexity in health care, we support practitioners in exercising their professional judgment to make informed decisions and offer quality care. We also support a consistent application of evidence-based guidelines to enhance clinical judgment and to ensure that treatment includes consideration of the practices that have been shown to be most effective for each individual's condition. In keeping with this commitment, we have continued to develop our Standards and Guidelines - Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders. These Criteria are intended to be a working document to help set expectations and facilitate a shared responsibility. These Criteria do not replace clinical judgment, and we recognize that they require adaptation to the unique situations of each individual patient, as well as to relevant state regulations and licensing standards.

We hope this document will prove to be a worthwhile resource, and we thank our practitioners for the outstanding work they do in helping individuals to live healthier, more balanced lives. At Cigna, we support open dialogue with our clinician community and all of our customers. We also welcome ongoing feedback to find ways that we can all work together to better serve you.

Douglas Nemecek, M.D., M.B.A.
Chief Medical Officer – Behavioral Health

Core Principles

General Overview

Cigna is committed to helping the people we serve improve their health, well-being, and sense of security. That is our mission. We realize that this is not possible without the understanding that mental health is equally important to physical health. There is a growing awareness across the United States of the influence of mental health and substance use conditions and the burden they place on individuals, families, and society. We believe that effective treatment for any illness must address mental health and physical health together. In fact, effective mental health and substance use disorder treatment is a cornerstone to driving holistic health and well-being. Taking this holistic view helps the people we serve be more productive at work, and more importantly, more productive at home with their families and in their communities.

At Cigna, we strongly believe that the core principle that guides mental health and substance use disorder care is that access to high quality care should be assured for everyone. This is true regardless of the diagnosis, treatment setting, type of clinician, geographic location, or the gender, ethnicity, or socioeconomic background of the individual seeking care. According to the 2005 Institute of Medicine report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions," there are six dimensions that need to be addressed in achieving high quality care for patients.¹ Quality mental health and substance use disorder care needs to be: safe, effective, patient-centered, timely, efficient, and equitable. Acceptance of these six dimensions of care is essential to delivering the most effective and most appropriate care to every patient. This Institute of Medicine report also identifies the importance of patient care being coordinated over time and across people, functions, activities, and treatment settings so that each patient receives the maximum benefit from their treatment services. It is from this core principle that Cigna has continued to develop our Standards and Guidelines - Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders.

Medical Necessity Criteria

Cigna begins with evidence-based guidelines as the basic platform to define established standards of effective care. Scientific evidence is the vital element in the development of an informed decision-making process for patients and their clinicians. Over the last 18 years, the Surgeon General², the President's New Freedom Commission on Mental Health³, and the Institute of Medicine¹ have all produced reports that highlight the importance of improving the dissemination and adoption of evidence-based practices. Effective treatment is ultimately linked to the consistent use of these evidence-based clinical practices and the ability of mental health and substance use disorder clinicians to effectively execute these therapies.

Cigna has adopted nationally developed and published clinical practice guidelines of the American Psychiatric Association, the American Association of Pediatrics and the National Institute on Alcohol Abuse and Alcoholism due to their acceptance as the best of evidence-based practice for mental health and substance use disorders. These evidence-based clinical practices then serve as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. Cigna has chosen not to adopt private, proprietary medical necessity criteria from companies such as McKesson Health Solutions or MCG, but to develop and implement our own. This decision strongly reflects our philosophy that Cigna's Criteria should reflect the mutual consensus of all of our stakeholders, be transparent and available to everyone, and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

In the development of our Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders, Cigna has listened to the messages and feedback from patients, families, advocacy groups (MHA and NAMI), professional associations (American Psychiatric Association, American Academy of Child and Adolescent Psychiatrists, American Psychological Association, Association for Ambulatory Behavioral Healthcare, and the American Society of Addiction Medicine), regulatory bodies, psychiatrists,

psychologists, and therapists across the country. We have attempted to incorporate the strongest, evidence-based points into our Criteria. These Criteria then become a working document to help set expectations and to facilitate a joint working relationship and shared responsibility between Cigna and mental health and substance use disorder clinicians.

It is important to note that these Criteria are established as national standards. However, we recognize that many states have established state-specific standards and expectations for care, and have codified these into state laws, regulations and licensing rules. Sometimes specific levels of care or programs are not available in certain markets. Cigna always approaches the application of these Criteria allowing for exceptions to be made to comply with state regulatory and licensing standards.

Cigna is proud to keep the development process of our Criteria open and transparent to the public. We appreciate the active and meaningful role that patients, clinicians, and advocates have in determining how the scientific evidence is applied in our Criteria. In addition to listening to their input, we have also worked to write our Criteria in words that everyone can understand. Our Criteria are only of value when we can have open, clear, and complete discussions, and when individuals and their clinicians can understand and use the Criteria in their behavioral healthcare decision making.

Cigna believes that all treatment decisions that are made in alignment with these Criteria must be first and foremost clinically based. Care must be patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual. In this way, the Criteria promote advocacy for the patient and enhance the collaboration between Cigna and clinicians to achieve optimal, patient-centered outcomes. They also promote consistent communication and coordination of care from one treatment setting to the next. Finally, our Criteria, and their application, are always governed by the terms of each individual customer's benefit plan and in accordance with applicable federal and state laws and regulations.

Providing every individual with access to quality, evidence-based, patient-centered care is the core tenet of our approach at Cigna. It is from this approach that our Standards and Guidelines - Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders help drive improvements in holistic health care and ensure consistent, meaningful outcomes for everyone.

Douglas Nemecek, M.D., M.B.A.
Chief Medical Officer – Behavioral Health

¹Improving the Quality of Health Care for Mental and Substance Use Conditions, Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board of Health Care Services. Washington DC: National Academies Press, 2005.

²Mental Health: A Report of the Surgeon General. Office of the Surgeon General, Public Health Service, Department of Health and Human Services. Washington DC, 1999.

³Achieving the Promise: Transforming Mental Health Care in America, The President's New Freedom Commission on Mental Health, Department

Mental Health Treatment for Adults

SECTION I.

Acute Inpatient Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Acute Inpatient Mental Health Treatment for Adults is utilized when the following services are needed:

- › Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring,
- › Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others,
- › Daily monitoring of medication effects and side effects; and,
- › A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Mental Health Treatment for Adults:

- › Within 24 hours prior to admission, there has been a face-to-face individual assessment by a licensed behavioral health clinician, with training and experience in the assessment and treatment of acute mental health disorders consistent with the age and problems of the individual. This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Acute Inpatient Mental Health Treatment for Adults:

- › A documented diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of acute distress/impairment.
- › Evaluation by a Board Certified/Board Eligible Psychiatrist within 24 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care.
- › A medical assessment and physical examination within the first 24 hours of admission.

- › Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist.
- › Psychiatric follow-up occurs daily or more frequently as needed.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions. Within 48 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › The facility will rapidly assess and address any urgent behavioral and/or physical issues.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less intensive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **Discharge planning** will start at the time of admission and include:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Acute Inpatient Mental Health Treatment for Adults

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has been diagnosed with a severe and acute mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, that is significantly impairing functioning.
3. **One or more of the following criteria must be met:**
 - A. It is likely that the individual is currently at imminent risk of causing serious bodily harm to him/herself or someone else due to a psychiatric illness, (not due to intentional criminal behavior), as evidenced by:
 - i) A recent and serious suicide attempt or threat of violence toward others involving deadly intent or plan, OR
 - ii) A current expression of suicidal intent or homicidal intent with a plan for bodily harm that has a high likelihood of becoming deadly or causing serious injury, OR
 - iii) Recent, serious and intentional self-injury along with an inability to develop a reasonable plan for safety so that 24 hour observation, safety measures, and treatment are needed in a secure setting, OR
 - iv) Recent violent, impulsive, and unpredictable behavior that is likely to result in harm to the individual or someone else without 24 hour observation and treatment, including the possible use of seclusion and/or restraints in a secured setting.
 - B. It is very likely that serious harm will come to the individual due to a psychiatric illness, and that harm cannot be prevented at a lower level of care as evidenced by:
 - i) The individual is unable to care for self (nutrition, shelter, and other essential activities of daily living) due to his/her psychiatric condition so that imminent life-threatening deterioration is expected, OR

- ii) The individual has irrational or bizarre thinking, and/or severe slowness or agitation in movements along with interference with essential activities of daily living of such severity as to require 24 hour skilled psychiatric/medical, nursing and social service interventions.
- C. The individual has a secondary condition such that treatment cannot be provided at a less restrictive level of care as evidenced by:
 - i) A life threatening complication of an eating disorder, OR
 - ii) An active general medical condition (i.e.; cardiac disease, pregnancy, diabetes, etc.) which requires that psychiatric interventions be monitored in a 24 hour psychiatric/medical setting, OR
 - iii) The individual requires Electroconvulsive Therapy (ECT) and the initial trial requires a 24 hour psychiatric/medical setting.
- D. Appropriate less restrictive levels of care are unavailable for safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Residential Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Residential Mental Health Treatment for Adults:

- › A facility that provides Residential Mental Health Treatment for Adults is either a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose and that includes 7 days per week, 24 hour supervision and monitoring.
 - Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
 - Facilities that provide Residential Mental Health Treatment for Adults are staffed by a multidisciplinary treatment team under leadership of a Board Certified/Board Eligible Psychiatrist who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - The program provides for the mental health and physical health needs of the individual.
 - A nurse is on-site 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.
 - A psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and prescribe medications as clinically indicated.
- › Treatment is focused on stabilization and improvement of functioning and reintegration with family or significant others.
 - Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued treatment services at less restrictive levels of care, as needed.
 - Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.
 - Residential treatment coverage is not based on a preset number of days.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

Note: Residential treatment is not a substitute for a lack of available supportive living environment(s) in the community.

:Examples of services that do not typically meet criteria for Residential Mental Health Treatment:

- › There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Residential Mental Health Treatment Facilities, or the equivalent, and that do not meet the above criteria. A few examples follow:
 - **Therapeutic Group Homes:** These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.
 - **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** “At times state statute defines ‘boot camps’ or ‘wilderness therapy programs’ as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most of the ‘boot camps’ and ‘wilderness programs’ do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child’s care. Also, the Joint Commission nearly universally denies certification for these types of programs that fail to meet the quality of care guidelines for medically supervised care from licensed mental health professionals.” (6)
 - **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration or simply as respite or housing.
 - **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

Admission Considerations for Residential Mental Health Treatment for Adults:

- › Within 72 hours prior to the request for admission, there has been a face-to-face assessment with the individual by a licensed behavioral health clinician, with training and experience consistent with the age and problems of the individual. This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Residential Mental Health Treatment for Adults:

- › A documented current diagnosis of a moderate-to-severe mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
- › Evaluation by a Board Certified/Board Eligible Psychiatrist within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.

- › A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
- › Residential treatment should occur as close as possible to the home and community to which the individual will be discharged.
 - If out-of-area placement is unavoidable, there must be consistent family involvement with the individual and regular family therapy and discharge planning sessions, unless clinically contraindicated.
- › Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
 - Therapeutic passes may occur, when clinically indicated, as part of the transition and discharge planning process to allow opportunity to practice therapeutic skills/gains with the family.
- › **A Preliminary Treatment Plan** is completed within 48 hours of admission and a **Comprehensive Treatment Plan** is to be completed within 5 days that includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessments of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.

- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Discharge planning** will start at the time of admission and include:
 - Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments, with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria - Residential Mental Health Treatment for Adults

Criteria for Admission

All of the following must be met:

1. All Elements of Medical Necessity must be met.
2. The individual is expressing willingness to actively participate in this level of care.
3. The individual has been diagnosed with a moderate-to-severe mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders and evidence of significant distress/impairment.
4. This impairment in function is seen across multiple settings such as work, home, and in the community, and clearly demonstrates the need for 24 hour skilled psychiatric and nursing monitoring and intervention.
5. As a result of the interventions provided at this level of care, the symptoms and/or behaviors that led to the admission can be reasonably expected to show improvement such that the individual will be capable of returning to the community and to less restrictive levels of care.

6. The individual is able to function with some independence, participate in structured activities in a group environment.
7. There is evidence that a less restrictive level of care is not likely to provide safe and effective treatment

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all Elements of Medical Necessity.

2. One or more of the following criteria must be met:

- A. The treatment provided is leading to measurable clinical improvements in the moderate-to-severe symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- B. If the treatment plan implemented is not leading to measurable clinical improvements in the moderate-to-severe symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Partial Hospital Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Partial Hospital Mental Health Treatment for Adults provides coordinated, intense, ambulatory, multi-disciplinary, and acute short-term treatment for individuals who can maintain personal safety with support systems in the community.

- › Treatment provided in this setting is similar in nature and intensity to that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.
- › Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
 - “Partial hospitalization programs (PHP’s) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu...
 - “PHP’s may pursue one or both of the following major functions:
 - Acute Crisis Stabilization
 - Acute Symptom Reduction.” (14)
- › A facility that provides Partial Hospital programs may be a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose, or a department within a general medical healthcare system.
- › An Individual in Partial Hospital Mental Health Treatment for Adults:
 - Is not appropriate for this level of care if he/she is imminently at risk of suicide or homicide and without sufficient impulse/behavioral control and/or minimum necessary social support.
 - Is having moderate-to-severe and acute psychiatric symptoms that are compromising daily functioning with work, parenting, school, and/or with other activities of daily living.
 - Has the ability:
 - To make basic decisions for him/herself AND

- To accept responsibility for his/her own actions.

Admission Considerations for Partial Hospital Mental Health Treatment for Adults:

- › Within 72 hours prior to the request for admission, there has been a face-to-face assessment by a licensed behavioral health clinician with training and experience consistent with the age and problems of the individual.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
 - Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of the individual within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - A medical assessment and physical examination within the first 72 hours of admission, unless a physician determines that a recent examination prior to admission to the facility was sufficient.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning

Expectations for Partial Hospital Mental Health Treatment for Adults:

- › Individuals who are at this level of care are typically in a structured treatment program 5 days per week with a minimum of 20 hours of scheduled programming.
- › All services offered must consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment.
- › **The individual is not considered a resident at the program.**
 - The patient lives in the community without the restrictions of a 24 hour supervised setting during non-program hours.
 - This level of care is only appropriate for individuals who are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
 - Partial hospital programs are expected to give individuals fully unsupervised, unstructured hours each day to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
 - During non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.

- › Cigna does not cover boarding for Partial Hospital programs, as this level of care is an ambulatory service.
- › The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- › During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board Eligible/Board Certified psychiatrist.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- > **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
 - This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

> **Discharge planning** will start at the time of admission and include:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
- Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Note: *This level of care should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.*

Medical Necessity Criteria – Partial Hospital Mental Health Treatment for Adults

Criteria for Admission

1. **All of the following must be met:**

- A. All elements of Medical Necessity must be met.
- B. The individual has been diagnosed with a moderate-to-severe and acute mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

2. **One or more of the following must be met:**

- A. **The individual is demonstrating significant acute impairments in functioning** secondary to a psychiatric disorder, as evidenced by both of the following:
 - i) **The individual is severely impaired** and is not able to complete essential daily social, family, school, and/or work activities AND
 - ii) **The individual is not able to employ sufficient coping skills** to compensate for this in the community without this intensity of treatment.

OR

- B. The individual has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24 hour monitoring environment.

OR

- C. The individual requires a structured program to manage acute psychiatric symptoms that are seriously interfering with treatment of a potentially life-threatening medical condition that cannot

be safely and effectively managed at a less restrictive level of care (e.g., pregnancy, uncontrolled diabetes).

OR

- D. The individual requires a structured program to manage acute medical symptoms that are seriously interfering with treatment of a serious co-existing psychiatric disorder that cannot be safely and effectively managed at a less restrictive level of care.

3. All of the following must be met:

- A. The individual is mentally and emotionally capable to actively engage in the treatment program.
- B. The individual is able to live in the community without the restrictions of a 24 hour supervised setting.
- C. The individual is expressing willingness to engage in treatment.
- D. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
- E. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR- If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
- F. If there are medical issues, they can be safely managed in a partial hospital level of care.

Criteria for Continued Stay

All of the following must be met:

- 1. The individual continues to meet all elements of Medical Necessity.
- 2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the moderate-to-severe and acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the moderate-to-severe and acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
- 3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Intensive Outpatient Mental Health Treatment for Adults provides a coordinated, intense, ambulatory, multi-disciplinary and time-limited treatment for individuals who can maintain personal safety with support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

- › A facility that provides Intensive Outpatient Mental Health Treatment for Adults may be a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose, or a department within a general medical healthcare system.
- › An Individual in Intensive Outpatient Mental Health Treatment for Adults:
 - Is not at imminent risk for serious bodily harm toward self or others.
 - Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
 - Has the ability:
 - To make basic decisions for him/herself AND
 - To accept responsibility for his/her own actions and behavior.
- › The duration of treatment and frequency of attendance are re-evaluated and adjusted according to the individual's severity of signs and symptoms.
- › Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- › This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the individual immediately returned to a less structured outpatient setting.

Note: *Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.*

Admission Considerations for Intensive Outpatient Mental Health Treatment for Adults:

- › Within 72 hours prior to admission, there has been a face-to-face individual assessment by a licensed behavioral health clinician with training and experience consistent with the age and problems of the individual.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of moderate distress/impairment.
 - Evaluation by a licensed behavioral health clinician with training and experience consistent with the age and problems of the individual within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Expectations for Intensive Outpatient Mental Health Treatment for Adults:

- › Individuals who are at this level of care are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
- › All services offered must consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment.
- › **The individual is not considered a resident at the program.**
 - The patient lives in the community without the restrictions of a 24 hour supervised setting during non-program hours.
 - This level of care is only appropriate for individuals who are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
 - Partial hospital programs are expected to give individuals fully unsupervised, unstructured hours each day to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
 - During non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.
- › Cigna does not cover boarding for Intensive Outpatient programs, as this level of care is an ambulatory service.

- › The facility provides a structured program, which is staffed by licensed behavioral health clinicians who are trained and experienced in the treatment of mental disorders.
- › Individual therapy sessions occur when clinically indicated.
- › A psychiatrist is available for consultation, as needed.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge Planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
 - This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual. .

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for

previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- > **Discharge planning** will start at the time of admission and include:
- Coordination with family, outpatient providers, and community resources to allow a smooth transition to a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Intensive Outpatient Mental Health Treatment for Adults

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has been diagnosed with a moderately severe mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. **The individual is demonstrating difficulties in functioning** secondary to a psychiatric disorder as evidenced by:
 - A. **The individual is mildly to moderately impaired** in his/her ability to complete essential daily social, family, school, and/or work activities, AND
 - B. **The individual is able to employ the necessary coping skills** to continue with most routine daily activities.
4. The individual is mentally and emotionally capable to actively engage in the treatment program
5. The individual is able to live in the community without the restrictions of a 24 hour supervised setting.
6. The individual is expressing willingness to engage in treatment.
7. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
8. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.

2. One or more of the following criteria must be met:

- A. The treatment provided is leading to measurable clinical improvements in the moderately severe symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- B. If the treatment plan implemented is not leading to measurable clinical improvements in the moderately severe symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Mental Health Treatment for Children and Adolescents

SECTION II.

Acute Inpatient Mental Health Treatment for Children and Adolescents

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Acute Inpatient Mental Health Treatment for Children and Adolescents is utilized when the following services are needed:

- › Around-the-clock intensive psychiatric/medical and nursing care including continuous observation and monitoring,
- › Acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others,
- › Daily monitoring of medication effects and side effects; and,
- › A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Mental Health Treatment for Children and Adolescents:

- › Within 24-hours prior to admission, there has been a face-to-face assessment by a licensed behavioral health clinician with training and experience in the assessment of acute mental health disorders in children and adolescents. This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Acute Inpatient Mental Health Treatment for Children and Adolescents:

- › A documented diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of acute distress/impairment.
- › Evaluation by a Board Certified/Board Eligible Child Psychiatrist with training and experience consistent with the age of the individual within 24 hours of admission who also reviews and

approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care.

- › A medical assessment and physical examination is completed within 24 hours of admission.
- › Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified Child Psychiatrist with training and experience consistent with the age and problems of children and adolescents.
- › Psychiatric follow-up occurs daily or more frequently as needed.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › Within 48 hours of admission there is outreach with existing providers and family members to obtain relevant history and clinical information, unless clinically contraindicated.
- › Young children (12 years and younger) will be admitted to a unit exclusively for children.
- › Ongoing academic schooling is provided to facilitate a transition back to the child's previous school setting.
- › The facility will rapidly assess and address any urgent behavioral and/or physical issues.
- › **Family Involvement** - *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore, prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less intensive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition to a less

restrictive treatment level of care, family integration, and continuation of the recovery process.

- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **Discharge planning** will start at the time of admission and include:
 - Coordination with family, outpatient providers, and community resources to facilitate a smooth transition back to home, family, work or school, and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Acute Inpatient Mental Health Treatment for Children and Adolescents

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The child/adolescent has been diagnosed with a severe and acute mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders that is significantly impairing functioning.
3. **One or more of the following criteria must be met:**
 - A. It is likely that the child/adolescent is currently at imminent risk of causing bodily harm to him/herself or someone else due to a psychiatric illness (not due to intentional criminal behavior) as evidenced by:
 - i) A recent and serious suicide attempt or threat of violence toward others involving deadly intent or plan, OR
 - ii) A current expression of suicidal intent or homicidal intent with a plan for bodily harm that has a high likelihood of becoming deadly or causing serious injury, OR

- iii) Recent serious and intentional self-injury, along with an inability to develop a reasonable plan for safety so that 24 hour observation, safety measures, and treatment are needed in a secure setting, OR
 - iv) Recent violent, impulsive and unpredictable behavior that is likely to result in harm to the individual or someone else without 24 hour observation and treatment, including the possible use of seclusion and/or restraints in a secured setting.
- B. It is very likely that serious harm will come to the child/adolescent due to a psychiatric illness, and that harm cannot be prevented at a lower level of care as evidenced by:
- i) The child/adolescent is unable to care for self (nutrition, shelter, and other essential activities of daily living) due to his/her psychiatric condition so that imminent life-threatening deterioration is expected, OR
 - ii) The child/adolescent has irrational or bizarre thinking, and/or severe slowness or agitation in movements along with interference with essential activities of daily living of such severity as to require 24 hour skilled psychiatric/medical, nursing and social service interventions.
- C. The child/adolescent has a secondary condition such that treatment cannot be provided at a less restrictive level of care as evidenced by:
- i) Serious medical complications of an eating disorder, OR
 - ii) An active general medical condition (i.e.; cardiac disease, pregnancy, diabetes, etc.) which requires that psychiatric interventions be monitored in a 24 hour psychiatric/medical setting, OR
 - iii) The child/adolescent requires Electroconvulsive Therapy (ECT) and the initial trial requires a 24 hour psychiatric/medical setting, OR
- D. Appropriate less restrictive levels of care are unavailable for safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The child/adolescent continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the child/adolescent is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and, modifications to the treatment plan that address specific barriers to achieving improvement, when clinically indicated.
 - C. The child/adolescent has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The child/adolescent and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Residential Mental Health Treatment for Children and Adolescents

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Residential Mental Health Treatment for Children and Adolescents:

- › Cigna agrees with the following principles, as stated by the American Academy of Child and Adolescent Psychiatry (6):
 - "The best place for children and adolescents is at home with their families. A child or adolescent with mental illness should be treated in the safest and least restrictive environment, and needed services should be 'wrapped-around' to provide more intensive home or community-based services.
 - "However, due to the severity of an individual’s psychiatric illness, there are times when a patient’s needs cannot be met in a community-based setting.
 - "When less restrictive resources are either unavailable or not appropriate for the patient’s needs, it might be necessary for a child or adolescent to receive treatment in a psychiatric residential treatment center (RTC)."
- › A facility that provides Residential Mental Health Treatment for Children and Adolescents is either a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose with 7-days per week, 24 hour supervision and monitoring.
 - Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
 - Facilities that provide Residential Mental Health Treatment for Children and Adolescents are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible Psychiatrist, with training and experience consistent with the age and problems of children and adolescents, who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly
 - The program provides for the child/adolescent’s mental health, physical health and educational needs, including intensive mental health care, physical health care, and access to on-going education at the appropriate developmental level.

- A nurse is on-site 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.
- A psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and prescribe medications as clinically indicated.
- › Treatment is focused on stabilization and improvement of functioning and reintegration with parents/relatives or guardians,
 - Residential treatment is transitional in nature for the purpose of returning the child/adolescent to the community with continued treatment services at a less restrictive level of care, as needed.
 - Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.
 - Residential treatment coverage is not based on a preset number of days.
 - Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

NOTE: Residential Treatment is not a substitute for lack of available supportive living environment(s) in the community.

- › **Examples of services that do not typically meet criteria for Residential Mental Health Treatment:** There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Residential Mental Health Treatment Facilities for Children and Adolescents, or the equivalent, and that do not meet all of the above criteria. A few examples follow:
 - **Therapeutic Group Homes:** These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.
 - **Therapeutic (Boarding) Schools:** The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.
 - **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** “At times state statute defines ‘boot camps’ or ‘wilderness therapy programs’ as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most of the ‘boot camps’ and ‘wilderness programs’ do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child’s care. Also, the Joint Commission nearly universally denies certification for these types of programs that fail to meet the quality of care guidelines for medically supervised care from licensed mental health professionals.” (6)
 - **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration within the juvenile justice or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or simply as respite or housing.

- **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

Admission Considerations for Residential Mental Health Treatment for Children and Adolescents:

- › Within 72 hours prior to the request for admission, there has been a face-to-face assessment with the child/adolescent and family by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents. This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Residential Mental Health Treatment for Children and Adolescents:

- › A documented current diagnosis of a moderate-to-severe mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
- › Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
- › A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
- › Residential treatment should occur as close as possible to the home and community to which the individual will be discharged.
 - If out-of-area placement is unavoidable, there must be consistent family involvement with the individual and regular family therapy and discharge planning sessions, unless clinically contraindicated.
- › Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › **Family Involvement** – *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore, prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.

- Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
- **Discharge planning**
 - Therapeutic passes may occur, when clinically indicated, as part of the transition and discharge planning process, to allow opportunity to practice therapeutic skills/gains with the family.
- › Ongoing academic schooling is provided to facilitate a transition back to the child's previous school setting.
- › Young children (12 years and younger) will be admitted to a unit exclusively for children.
- › **A Preliminary Treatment Plan** is completed within 48 hours of admission and a **Comprehensive Treatment Plan** is to be completed within 5 days that includes:
 - A clear focus on the issues leading to the admission and on the symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessments of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition to a less restrictive treatment level of care, family integration, and continuation of the recovery process.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - This plan should:
 - Be developed jointly with the family and the child/adolescent.
 - Establish realistic, specific, measurable, and achievable goals.
 - Include treatment modalities that are appropriate to the clinical needs of the child or adolescent.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Discharge planning** will start at the time of admission and include:
 - Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments, with at least one appointment within 7 days of discharge.

- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Residential Mental Health Treatment for Children and Adolescents

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The child/adolescent has been diagnosed with a moderate-to-severe mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders and evidence of significant distress/impairment.
3. This impairment in function is seen across multiple settings such as; school, home, work, and in the community, and clearly demonstrates the need for 24 hour skilled psychiatric and nursing monitoring and intervention.
4. As a result of the interventions provided at this level of care, the symptoms and/or behaviors that led to the admission can be reasonably expected to show improvement such that the individual will be capable of returning to the community and to a less restrictive level of care.
5. The child/adolescent is able to function with age-appropriate independence, participate in structured activities in a group environment, and both the individual and family are willing to commit to active regular treatment participation.
6. There is evidence that a less restrictive or intensive level of care is not likely to provide safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the moderate-to-severe symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care,
 - B. If the treatment plan implemented is not leading to measurable clinical improvements the moderate-to-severe symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement, when clinically indicated,
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The child/adolescent and family are involved to the best of their ability in the treatment and discharge planning process.

- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Partial Hospital Mental Health Treatment for Children and Adolescents

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Partial Hospital Mental Health Treatment for Children and Adolescents

provides coordinated, intense, ambulatory, multi-disciplinary and acute short-term treatment for individuals who can maintain personal safety with support systems in the community.

- › Treatment provided in this setting is similar in nature and intensity to that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.
- › Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
 - “Partial hospitalization programs (PHP’s) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu...
 - “PHP’s may pursue one or both of the following major functions:
 - Acute Crisis Stabilization
 - Acute Symptom Reduction.” (14)
- › A facility that provides Partial Hospital programs may be a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose, or a department within a general medical healthcare system.
- › An Individual in Partial Hospital Mental Health Treatment for Children and Adolescents:
 - Is not appropriate for this level of care if they are imminently at risk of suicide or homicide and without sufficient impulse/behavioral control and/or minimum necessary social support.
 - Is having moderate-to-severe and acute psychiatric symptoms that are compromising daily functioning with school, work, and/or with other activities of daily living.
 - Has the ability:
 - To make age-appropriate basic decisions for him/herself AND
 - To accept responsibility for his/her own actions.

Admission Considerations for Partial Hospital Mental Health Treatment for Children and Adolescents:

- › Within 72 hours prior to the request for admission, there has been a face-to-face assessment with the child/adolescent and family by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
 - Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - A medical assessment and physical examination within the first 72 Hours of admission, unless a physician determines that a recent examination prior to admission to the facility was sufficient.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Expectations for Partial Hospital Mental Health Treatment for Children and Adolescents:

- › Individuals who are at this level of care are typically in a structured treatment program 5 days per week with a minimum of 20 hours of scheduled programming.
- › All services offered must consist of active treatment that specifically addresses the presenting problems of the children/adolescents served and realistic goals that can be accomplished within the duration of treatment.
- › **The child or adolescent is not considered a resident at the program.**
 - The child/adolescent lives in the community without the restrictions of a 24 hour supervised setting during non-program hours, as age appropriate.
 - This level of care is only appropriate for children or adolescents who are capable of safely controlling their behavior and have family or guardians who are capable of seeking professional assistance or other support as needed.
 - Partial hospital programs are expected to give children or adolescents unsupervised, unstructured hours each day, as age appropriate, to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.

- During non-program hours, a child or adolescent who is living at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others except as age-appropriate.
- › Cigna does not cover boarding for Partial Hospital programs as this level of care is an ambulatory service.
- › The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- › During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents.
- › **Family Involvement** - *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore, prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › Ongoing academic schooling is provided to facilitate a transition back to the child's previous school setting.
- › Young children (12 years and younger) will be admitted to a unit exclusively for children.
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.

- This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

› **Discharge Planning** will start at the time of admission and include:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to a less restrictive level of care.
- Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Note: *This level of care should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.*

Medical Necessity Criteria – Partial Hospital Mental Health Treatment for Children and Adolescents

Criteria for Admission

1. **All of the following must be met:**

- A. All elements of Medical Necessity must be met.
- B. The child/adolescent has a documented diagnosis of a moderate-to-severe and acute mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

2. **One or more of the following must be met:**

- A. **The child/adolescent is demonstrating significant acute impairments in functioning** secondary to a psychiatric disorder, as evidenced by both of the following:
 - i) **The child/adolescent is severely impaired** and is not able to complete essential daily social, family, school, and/or work activities, AND
 - ii) **The child/adolescent is not able to employ sufficient coping skills** to compensate for this in the community without the intensity of treatment.

OR

- B. The child/adolescent has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24 hour monitoring environment,

OR

- C. The child/adolescent requires a structured program to manage acute psychiatric symptoms that are seriously interfering with treatment of a potentially life-threatening medical condition that cannot be safely and effectively managed at a less restrictive level of care. (e.g., pregnancy, uncontrolled diabetes)

OR

- D. The child/adolescent requires a structured program to manage acute medical symptoms that are seriously interfering with treatment of a serious co-existing psychiatric disorder that cannot be safely and effectively managed at a less restrictive level of care.

3. All of the following must be met:

- A. The child/adolescent is mentally and emotionally capable to actively engage in the treatment program.
- B. The child/adolescent is able to live in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate for children and adolescents.
- C. The child/adolescent is expressing willingness to engage in treatment.
- D. The child/adolescent and the family are able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
- E. The child/adolescent has a support system that includes family or guardians who are able to actively participate in treatment.
- F. If there are medical issues, they can be safely managed in a partial hospital level of care.

Criteria for Continued Stay

All of the following must be met:

- 1. The child/adolescent continues to meet all elements of Medical Necessity.

2. One or more of the following criteria must be met:

- A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
- C. The child/adolescent has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- A. The child/adolescent and family are involved to the best of their ability in the treatment and discharge planning process.
- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Mental Health Treatment for Children and Adolescents

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Intensive Outpatient Mental Health Treatment for Children and Adolescents

provides a coordinated, ambulatory, multi-disciplinary, time limited treatment for individuals who can maintain personal safety with support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

- › A facility that provides Intensive Outpatient Mental Health Treatment for Children and Adolescents may be a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose, or a department within a general medical healthcare system.
- › An Individual in Intensive Outpatient Mental Health Treatment for Children and Adolescents:
 - Is not at imminent risk for serious bodily harm toward self or others.
 - Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
 - Has the ability:
 - To make age-appropriate basic decisions for him/herself AND
 - To accept age-appropriate responsibility for his/her own actions.
- › The duration of treatment and frequency of attendance are re-evaluated and adjusted according to the individual's severity of signs and symptoms.
- › Clinical interventions may include individual, family, and group psychotherapies along with medication management.
- › This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the individual immediately returned to a less structured outpatient setting.

Note: *Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.*

Admission Considerations for Intensive Outpatient Mental Health Treatment for Children and Adolescents:

- › Within 72 hours prior to admission, there has been a face-to-face assessment with the child/adolescent and family by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of moderate distress/impairment.
 - Evaluation by a licensed behavioral health clinician with training and experience consistent with the age and problems of the individual within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Expectations for Intensive Outpatient Mental Health Treatment for Children and Adolescents:

- › Individuals who are at this level of care are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
- › All services offered must consist of active treatment that specifically addresses the presenting problems of the children and adolescents served and realistic goals that can be accomplished within the duration of treatment.
- › **The child or adolescent is not considered a resident at the program.**
 - The child/adolescent lives in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate, during non-program hours,
 - This level of care is only appropriate for children/adolescents who are capable of safely controlling their behavior and who have family or guardians who are capable of seeking professional assistance or other support as needed.
 - Intensive Outpatient programs are expected to give children and adolescents age-appropriate unsupervised, unstructured hours each day to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
 - During non-program hours, a child or adolescent who is living at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others except as age-appropriate.
- › Cigna does not cover boarding for Intensive Outpatient programs, as this level of care is an ambulatory service.

- › The facility provides a structured program, which is staffed by licensed behavioral health clinicians with training and experience consistent with the age and mental health problems of children and adolescents.
- › Individual therapy sessions occur when clinically indicated.
- › A psychiatrist is available for consultation, as needed.
- › **Family Involvement** - *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore, prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the symptoms which need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, and family therapies as appropriate.
 - The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
 - This plan should:
 - Be developed jointly with the child/adolescent and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the child/adolescent.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Discharge planning** will start at the time of admission and include:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Intensive Outpatient Mental Health Treatment for Children and Adolescents

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The child/adolescent has a documented diagnosis of a moderately severe mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. **The child/adolescent is demonstrating difficulties in functioning** secondary to a mental health disorder as evidenced by:
 - A. **The child/adolescent is mildly- to-moderately impaired** in his/her ability to complete essential daily social, family, school, and/or work activities, AND
 - B. **The child/adolescent is able to employ sufficient coping skills** to continue with most routine daily activities.
4. The child/adolescent is mentally and emotionally capable to actively engage in the treatment program
5. The child/adolescent is able to live in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate for children and adolescents.
6. The child/adolescent is expressing willingness to engage in treatment.
7. The child/adolescent and the family are able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
8. The child/adolescent has a support system that includes family or guardians who are able to actively participate in treatment.

Criteria for Continued Stay

All of the following must be met:

1. The child/adolescent continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The child/adolescent has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The child/adolescent and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Outpatient Treatment

SECTION III.

Outpatient Behavioral Health Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Outpatient Behavioral Health Treatment has the following focus and goals:

- › Reduce or alleviate the individual's symptoms,
- › Return individual to baseline or improve the level of functioning; and/or
- › Prevent imminent deterioration that would lead to a need for admission to a more intensive level of care.

Outpatient Treatment may consist of Individual Therapy, Group Therapy, or Family Therapy, Medication Management, or any combination of these four types of treatment.

Individual Therapy

This is a process in which an individual is involved in a therapeutic setting with a licensed mental health or substance use clinician on an individual basis.

- > Individual therapy should be considered when:
 - The individual is experiencing symptoms or impairments that are impacting their day-to-day functioning, relationships, work or school performance.
 - The individual has been unable to alleviate their symptoms on their own and/or is in need of additional assistance to relieve their symptoms.

Group Therapy

This is a process in which a number of people are involved in a therapeutic setting at the same time under the guidance of a licensed mental health or substance use clinician. Groups focus on an individual within the context of a group, on interactions that occur among individuals in the group, or on the group as a whole.

- > Group therapy may be considered when:
 - Problems are best treated in a social context,
 - Peer group interaction will enhance the effectiveness of problem solving,
 - Creating bonds or learning about the impact one has on others is important for symptom resolution and growth, or
 - Useful solutions may be better heard from peers.

Family Therapy

The identified patient in family therapy may be a child, adolescent or adult.

- > Family therapy should be considered when:
 - The family is affected by either the individual's condition or the individual's treatment.
 - The individual's symptoms or lack of functioning is reflective of family problems.
 - The family is compromising the individual's progress.
 - The treatment objectives can most efficiently be achieved by working with the family.
 - The individual has failed to make expected progress, and family interventions would be expected to improve treatment progress—indicators include medication noncompliance, failure to maintain abstinence from substance use or other self-harming behaviors, and/or recurrent hospitalizations.
 - The identified individual is a child/adolescent or a young adult still living at home and/or requires parental resources for appropriate functioning.

Medication Management:

- › There are a few biologically-based psychiatric conditions that require long-term, continuous medication management and follow-up to prevent or minimize the frequency and severity of acute symptom relapse that could require higher levels of care;
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › The need for ongoing medication management does not necessarily indicate that continued outpatient therapy is medically necessary.

Expectations for Outpatient Behavioral Health Treatment:

- › The therapist and individual will collaborate to establish clearly defined treatment objectives and to identify ways to measure improvement.
- › From time to time, individuals may occasionally have other unresolved problems, but their level of functioning has been restored to baseline. The presence of unresolved issues does not necessarily indicate that continued outpatient therapy is medically necessary.
- › The type and degree of functional impairment will be reflected in the treatment plan.
- › Treatment will be solution-focused and highly interactive.
- › In most cases, there is an expectation that therapy will terminate once the objectives of the treatment episode have been met.
- › Extended therapy visits (i.e., sessions lasting more than 50 minutes) and multiple visits per week are not provided as a routine, and are typically reserved for times when there is a compelling acute clinical reason for an individual to require an extended session.
- › For individuals with a history of multiple treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.
- › Cigna does not authorize treatment that is not HIPAA compliant. As such, requests for therapy sessions via popular social media apps or other non-HIPAA compliant means of communication cannot be approved.

Note: *Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Mental Health and/or Substance Use Disorders Treatment.*

Medical Necessity Criteria – Outpatient Behavioral Health Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of a mental health disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. For all modalities of psychotherapy ALL of the following must be met:
 - A. The individual reports or expresses a subjective level of distress.
 - B. Clinical symptoms result in functional impairment (impairment in ability to complete activities of daily living, occupational functioning, and/or social functioning that is not characteristic of the person when not symptomatic).
 - C. The individual is motivated for, or amenable to, treatment by a licensed mental health or substance use clinician.

Criteria for Continued Stay

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual continues to experience mental health and/or substance use symptoms and functional impairment.
3. The individual (and family as appropriate) has participated in the development of an individualized treatment plan. The treatment plan should include clearly defined, measurable, and realistic goals and discharge criteria, with an expected timeframe for completion.

In addition, Continued Stay guidelines are NOT met if any of the following are the case:

1. The individual is uncooperative or noncompliant with treatment, and the absence of treatment poses no imminent risk of harm to the welfare of the individual or others.
2. The individual's history provides evidence that additional outpatient therapy will not create further symptom relief and/or change.
3. Treatment is primarily supportive in nature.
4. Treatment is focused on phase of life, life transition, or quality of life issues (for example, career dissatisfaction, adjusting to new life circumstances in the absence of functional impairments) rather than on treating a psychiatric illness.
5. Treatment is open-ended without clearly defined, measurable, and realistic goals and discharge criteria, with an expected timeframe for completion.

Telehealth Services

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Telehealth Services encompass the delivery of health-related services and information through telecommunications technologies to improve a patient's clinical health status. Telehealth includes a growing variety of applications and services using two-way video, smart phones, wireless devices, and other forms of video telecommunications technology.

Telehealth is not a medical specialty in itself but a healthcare delivery modality, which is expected to increase access and decrease the cost of delivering care.

Expectations for Telehealth Services

A Professional Service - To provide a safe telehealth environment, providers are expected to follow the same professional judgment and ethical principles as they would in "face-to-face" visits, including when and how they choose to employ these technologies. Providers are expected to consider the patient's condition, circumstances, available resources, and their own comfort level and expertise when using telehealth.

Legal Issues - Providers need to be aware of all relevant state and federal laws related to the use of telehealth to include those that govern prescribing and the establishment of a doctor-patient relationship. In addition, providers need to be aware of relevant practice guidelines developed by the specialty societies as they relate to both in-person and telehealth practices. Providers are expected to:

- Abide by state board and specialty training and supervision requirements.
- Ensure that they are appropriately licensed to provide services in each state where patients are physically located at the time of treatment.

HIPAA - The provider who offers telehealth services should take care to ensure that the technology they are using is sufficiently secure that it protects the patients' rights for confidentiality and privacy and is in compliance with the Privacy and Security Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations (45 C.F.R. Parts 160- 164) and applicable state laws.

Standards of Care - The provider is responsible for determining the appropriateness of telehealth services for each appointment prior to any telehealth visit. The provider needs to have access to necessary information on medical history, presenting symptoms/problems, reimbursement method, and primary care providers. In addition, the provider is expected to set appropriate expectations regarding the telehealth visit, including for example, prescribing policies, scope of service, communication, emergency plans, and follow-up.

During a telehealth visit, the provider must assure that the examination provides information equivalent to an in-person exam and conforms to the standards of care expected of in-person visits.

Communication and Documentation - Following every visit, the provider is expected to document and communicate the outcome of the encounter to the patient's primary care provider or other specialty providers using secure methods (e.g., fax, secure email, transmit to EMR), as well as to the patient, unless the patient has not given consent for that communication.

Telephonic sessions are not considered to be medically necessary or appropriate as a substitute for face-to-face or video therapy visits.*

- Without a face to face (or video) examination, a phone call alone does not allow for a proper exam and the legally/medically proper physician-patient relationship.
- This is especially true for behavioral health where visual cues and body language are important aspects of any assessment and Mental Status Exam.
- In general an examination through telemedicine technology should provide the practitioner with information that is equivalent to an in-person examination.

**Exceptions may be considered if an individual is incapacitated, homebound, and physically or mentally unable to attend face-to-face or video treatment sessions, or when required by applicable federal and/or state mandates.*

Coverage – Benefit coverage for Behavioral Telehealth sessions are available to most Cigna customers and administered in accordance with the customer's benefit plan. Telehealth sessions may be used for many face-to-face services including therapy and medication management.

Note: Telehealth Services may be excluded under some Cigna Behavioral Health benefit plans, and may be governed by federal and/or state mandates. Cigna does not generally cover Telehealth for individuals who are outside of the United States. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage

Medical Necessity Criteria – Telehealth Services

Telehealth services must meet the same Medical Necessity criteria as face-to-face encounters for the type of service being provided.

Halfway House for Mental Health & Substance Use Disorders

Standards and Guidelines

Note: *Benefit coverage for Halfway House placement is excluded under many Cigna Behavioral Health benefit plans, and may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.*

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Halfway House for Mental Health & Substance Use Disorders will:

- › Be licensed to provide services for individuals with substance use disorders and/or other behavioral health disorders by an appropriate state licensing certification board in the state where the care is provided.
- › Provide 24 hour monitoring of the individual and the immediate physical surroundings to ensure a safe, clean and sober environment.
- › Have clinical oversight provided by licensed medical professionals or substance use disorders counselors.
- › Have the capability to provide medical and psychiatric referrals for treatment and follow up of underlying physical and/or psychiatric illnesses, and
- › Require abstinence from mood-altering chemicals unless appropriately prescribed by a licensed physician.
- › Be used for stabilization of the individual and preparation for transition to a less restrictive level of care with a goal of reintegration into the individual's community.

Admission Considerations for Halfway House for Mental Health & Substance Use Disorders:

- › A Halfway House admission may be considered when an appropriate, less restrictive level of care is unavailable.
- › Relapse should not be the sole criteria for transferring an individual to a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and family, the risk of danger or harm to the individual or others, and

the reason for the relapse. An updated and modified treatment plan should then include addressing the barriers to continued relapse, the relapse triggers, and the prevention plan.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Expectations for Halfway House for Mental Health & Substance Use Disorders:

- › Staff will actively work with the individual to ensure he/she fully participates in substance use treatment, which can include on-site or community-based outpatient individual, group, and family treatment, all while residing in the Halfway House.
- › The staff and program of the Halfway House are focused on reducing the risk of relapse, reinforcing pro-social behaviors, and assisting in community reintegration.
- › The Halfway House will have a documented and regularly updated care plan that addresses the individuals' behavioral health needs.
- › The discharge plan will include:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments.

Medical Necessity Criteria – Halfway House for Mental Health & Substance Use Disorders

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. **All of the following criteria must be met:**
 - A. The individual is medically stable and not experiencing medical complications that would preclude active participation in treatment. The individual is cognitively able to actively participate in and benefit from behavioral health treatment.
 - B. The individual demonstrates an interest in working toward the goal of rehabilitation.
 - C. The individual is actively engaged in treatment, which must include on-site or community-based outpatient individual, group, and family treatment, or IOP/PHP, and staff at the halfway house have reviewed and agree with the treatment plan.
3. **One or more of the following criteria must be met:**
 - A. Prior to entering into the Halfway House setting, the individual:
 - i) Has been unsuccessful in achieving sustained abstinence of 6 months or more following active participation in an outpatient rehabilitation program (intensive outpatient and/or partial hospitalization) during the past 12 months, OR
 - ii) Has failed to follow-through with outpatient rehabilitation, including intensive outpatient and/or partial hospitalization, OR
 - iii) Has demonstrated a repeated inability to control his/her impulses to use drugs/alcohol. For an individual with a history of repeated relapses and treatment history involving multiple

- treatment episodes, there must be evidence of the rehabilitation potential for the proposed admission, with clear interventions, and definition of noncompliance and its management, OR
- B. The individual's living environment is such that his/her ability to successfully achieve abstinence is jeopardized. Examples would be: the family is opposed to the treatment efforts, the family is actively involved in their own substance use, and/or the living situation is severely dysfunctional, OR
 - C. The individual's social, family, and occupational functioning is severely impaired secondary to substance use, such that most daily activities revolve around obtaining, using, and recuperating from substance use. While the individual is expressing an interest in abstinence, he/she requires 24 hour supportive living environment to engage and maintain therapeutic gains.

Criteria for Continued Stay

All of the following must be met:

1. All elements of Medical Necessity continue to be met.
2. The individual recognizes or identifies with the severity of the behavioral health problem.
3. **One or more of the following criteria must be met:**
 - A. There is evidence that the individual requires continuing support to maintain continued sobriety.
 - B. There is evidence that the individual requires continuing support to maintain insight into self-defeating behaviors associated with behavioral health.
 - C. There is evidence that the individual requires continuing support to maintain the problem solving skills necessary to address their behavioral health
 - D. There is evidence that the individual requires continuing support to manage personal triggers associated with relapse.
4. **All of the following must be met:**
 - A. The individual is actively engaged in on-site or community-based outpatient individual, group, and/or family treatment or IOP/PHP.
 - B. The individual is actively pursuing independent living arrangements.
 - C. There is clinical evidence as to why other living arrangements, with or without the use of other treatment services, would not sustain the individual's progress.
 - D. The individual is improving clinically and progressing toward discharge from the present level of care.
 - E. The individual and family are involved to the best of their ability in the treatment and discharge planning process.

Substance Use Disorders Treatment

SECTION IV.

Acute Inpatient Substance Use Detoxification

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Acute Inpatient Substance Use Detoxification is utilized when the following services are needed:

- › Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring,
- › Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others.
- › Medications are prescribed and adjusted as indicated to assure that the individual has a safe and effective withdrawal from alcohol, sedative-hypnotic medications, or opiates.
- › Appropriate medical professionals are available, including physician visits at least once each day and 24 hour nursing staff monitoring,
- › Daily monitoring of medication effects and side effects; and,
- › A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Substance Use Detoxification:

- › Prior to admission, there has been a face-to-face assessment by a licensed clinician with training and experience in acute psychiatric emergencies and medical detoxification, to determine if this level of care is medically necessary and clinically appropriate due to a significant risk of a severe withdrawal syndrome.
- › This level of care is not justified by simple intoxication or fear of withdrawal. Therefore, elevated blood alcohol level without any associated withdrawal symptoms is not enough to justify detoxification treatment.
- › It is recognized that life-threatening intoxication/poisoning (i.e. endangering vital functions – central nervous system, cardiac, respiratory) may need acute medical attention, but that attention is generally not considered detoxification. In such cases, treatment at a medical/surgical unit may be needed and medical necessity criteria are applied when the individual has acute and severe medical problems such as:
 - Acute onset of seizures, severe electrolyte imbalance, gastrointestinal bleeds, cardiac complications, acute liver failure, or other serious medical complications, OR

- Underlying substance use is of such severity that it will likely cause severe and acute medical complications in the near future requiring acute medical management.

Expectations for Acute Inpatient Substance Use Detoxification:

- › A documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of acute distress/impairment and risk for a severe withdrawal syndrome.
- › A thorough Evaluation by a psychiatrist or addictionologist is completed within 24 hours of admission.
- › A medical assessment and physical examination is completed within 24 hours of admission.
- › Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.
- › Physician follow-up occurs daily or more frequently as needed.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › Within 48 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › For individuals under the age of 18, a face-to-face assessment that includes both the child/adolescent and the family is completed within 24 hours of admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › The facility will rapidly assess and address any urgent behavioral and/or physical issues.
- › Coordination of treatment planning with community treatment providers, employers, or any involved legal authorities is an essential part of treatment and discharge planning.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the acute symptoms that need to improve to allow treatment to continue at a less restrictive level of care.

- Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
 - Clear, objective and observable discharge criteria.
 - A discharge plan that includes coordination with family and community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
- › The Treatment Plan is not based on a pre-established programmed plan or time frames.
- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **Discharge Planning** will start at the time of admission and include:
- Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Acute Inpatient Substance Use Detoxification

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. The individual is at risk for a severe withdrawal syndrome as evidenced by **one or more of the following:**
 - A. **Severe Alcohol and/or Sedative-Hypnotic Withdrawal** with evidence of recent use of these substances and **one or more of the following:**
 - i) Abnormal vital signs (blood pressure, temperature, pulse, and respirations), or elevated scores on clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), AND some or all of the following observable,

objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting, clouding of sensorium, delirium, seizures, and/or hallucinations, OR

- ii) The Individual has a pattern of alcohol and /or benzodiazepine use of such severity that it will likely result in a severe withdrawal syndrome with acute medical complications in the immediate future requiring acute 24 hour medical and nursing management, OR
- iii) Prior complicated and potentially life-threatening withdrawal with a history of seizures, delirium tremens, or hallucinations associated with alcohol and/or sedative-hypnotic use or withdrawal.

B. **Severe Opiate Withdrawal** as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, sweating, diarrhea, dilated pupils, irritability, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, and/or yawning,

AND

4. **One or more of the following must apply:**

- A. The presenting signs and symptoms require active treatment that can only be safely and effectively provided in a 24 hour per day setting with nursing care and daily medical interventions,
- B. The Individual is currently suffering from symptoms of a severe mental illness or has such irrational or bizarre thinking that he/she could not be safely treated in a less intensive level of care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.

2. **One or more of the following criteria must be met:**

- A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement, when clinically indicated
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**

- A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Ambulatory Substance Use Detoxification

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Note: Ambulatory Substance Use Detoxification programs are not available in all states or markets. This guideline is used when services are provided by a free-standing ambulatory detoxification program. When a customer is being monitored and treated for mild to moderate withdrawal symptoms while participating in an Intensive Outpatient Substance Use Disorder Program or Partial Hospital Substance Use Disorder Program, no additional authorization is required for those services.

Description – Ambulatory Substance Use Detoxification is utilized when there is a need for medical monitoring of mild to moderate withdrawal symptoms.

- › Medications are prescribed and adjusted as indicated to assure that the individual has a safe and effective withdrawal from alcohol, sedative-hypnotic medications, or opiates.
- › Appropriate medical professionals are available, which may include a psychiatrist or addictionologist and daily monitoring by nursing staff.
- › There is 24 hour access to a physician should unexpected symptoms or worsening of symptoms occur.

Admission Considerations – Ambulatory Substance Use Detoxification:

- › Prior to admission, there has been a face-to-face individual assessment by a licensed physician or nurse practitioner with training and experience in acute psychiatric emergencies and medical detoxification, and consistent with the age and problems of the individual, to determine if this level of care is medically necessary and clinically appropriate.
- › The individuals managed at this level of care do not require medical monitoring on a 24 hours a day basis.
- › The facility has the ability to step up the individual to an inpatient detoxification level of care, if needed.

Expectations for Ambulatory Substance Use Detoxification:

- › A documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of acute distress/impairment and risk for moderately severe withdrawal syndrome.
- › Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.

- › This level of care is used as a time-limited level of intervention to stabilize acute withdrawal symptoms, facilitating a transition to a less restrictive level of care when clinically indicated.
- › Individuals and/or their families/significant others are capable of accessing emergency services, if needed.
- › Individuals in this level of care live in the community without the restrictions of a 24 hour supervised setting
- › The program facilitates engagement of individuals in treatment and recovery programs, including community based self-help groups, and development of a social support network to ensure long-term sobriety.
- › Coordination with community treatment providers, employers, or any involved legal authorities is part of the treatment and discharge planning
- › Psychiatric and/or substance use treatment is addressed concurrently, as needed; to improve the individual's potential for recovery.
- › For individuals under the age of 18, a face-to-face assessment that includes both the child/adolescent and the family is completed within 24 hours of admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the acute symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
 - Clear, objective and observable discharge criteria.
 - A discharge plan that includes coordination with family and community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
- › The Treatment Plan is not based on a pre-established programmed plan or time frames.
- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **Discharge Planning** will start at the time of admission and include:
- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care
 - Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Ambulatory Substance Use Detoxification

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. The individual is at risk for a withdrawal syndrome as evidenced by either abnormal vital signs (blood pressure, temperature, pulse, and respirations), or elevated scores on clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), plus **one or more of the following:**
 - A. **Alcohol and/or Sedative-Hypnotic Withdrawal** as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting,

OR

 - B. **Opiate Withdrawal** as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: 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.

4. The presenting signs/symptoms must be causing clinically significant distress or impairment of social, occupational, or other important areas of functioning,
5. The individual does not require around-the-clock nursing care.
6. **When there is a history of repeated relapses and/or multiple failed treatment episodes**, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:
 - Includes clear interventions specifically addressing prior non-adherence and poor response to treatment
 - Includes clear interventions that are likely to reduce the frequency and severity of future relapse.
 - Has the goal of maintaining abstinence.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.,
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that addresses specific barriers to achieving improvement when clinically indicated.,
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Acute Inpatient Substance Use Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Acute Inpatient Substance Use Disorders Treatment is utilized when the following services are needed:

- › Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
- › Timely assessment and medically-necessary treatment of co-existing acute medical or psychiatric problems.
- › Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others.
- › Daily monitoring of medication effects and side effects.
- › A contained environment for specific treatments that could not be safely done in a non-monitored setting.

NOTE: *Acute Inpatient Substance Use Disorders Treatment may also be identified as Inpatient Rehabilitation, Mentally Ill Chemical Abuse (MICA) Treatment, or Dual Diagnosis Inpatient Treatment.*

Admission Considerations for Acute Inpatient Substance Use Disorders Treatment:

- › Prior to admission, there has been a face-to-face individual assessment by a licensed clinician, with training and experience in acute psychiatric and medical emergencies consistent with the age and problems of the individual, to determine if this level of care is medically necessary and clinically appropriate.
- › Alternative medical, substance use detoxification, psychiatric treatment programs, are considered and referrals made when clinically indicated.
- › Substance use inpatient treatment may be a consideration when appropriate alternative less restrictive levels of care are unavailable.

Expectations for Acute Inpatient Substance Use Disorders Treatment:

- › A documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

- › A thorough Evaluation by a psychiatrist or addictionologist is completed within 24 hours of admission.
- › A medical assessment and physical examination is completed within 24 hours of admission. (or per relevant state regulatory or licensing standards)
- › Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.
- › Physician follow-up occurs daily or more frequently as needed.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › Within 48 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 24 hours of admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › The facility will rapidly assess and address any urgent behavioral and/or physical issues
- › There is adequate nursing support, along with staffing by appropriately-trained clinicians, and availability of appropriate physician expertise (such as psychiatrist or addictionologist).
- › The facility has the capability of obtaining necessary consultation(s) based on individual's clinical needs such as pain management specialist for individuals with significant pain issues.
- › The facility has the capability of monitoring the individual's daily medical functioning. Such clinical monitoring may include measurement of the vital signs, performing objective clinical assessment(s) to monitor for prolonged withdrawal and obtaining necessary laboratory work up, as indicated.
- › Treatment is focused on stabilization of acute medical or psychiatric issues and initial engagement in substance use rehabilitation and development of a plan for successful transition to less restrictive settings and community re-integration.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:

- A clear focus on the issues leading to the admission and on the acute symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
 - Clear, objective and observable discharge criteria.
 - A discharge plan that includes coordination with family and community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.
- › The Treatment Plan is not based on a pre-established programmed plan or time frames.
- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **Discharge Planning** will start at the time of admission and include:
- Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Acute Inpatient Substance Use Disorders Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. **All of the following must be met:**
 - A. Withdrawal symptoms, if present, are not life threatening and can be safely monitored.
 - B. The individual is not experiencing medical complications that would preclude active participation in treatment, AND

C. The individual is cognitively able to actively participate and benefit from the treatment provided,

4. One or more of the following criteria must be met:

A. The individual demonstrates a clear and reasonable danger of imminent harm to self or others that is caused by or exacerbated by the current active substance use disorder as evidenced by one of the following:

- i) Current plan or intent to harm self with an available and lethal means, OR
- ii) Highly lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.

OR

B. Inability to care adequately for one's physical safety due to disordered, disorganized or bizarre behavior, OR

C. Current plan/intent to harm others with available and lethal means with inability to plan reliably for safety, OR

D. Violent, unpredictable, or poorly controlled behavior that represents an imminent serious harm to others, OR

E. The individual's medical condition and continued substance use places the individual in imminent danger of serious damage to his/her physical health or to a current pregnancy. The individual requires 24 hour monitoring, but not the full resources of an acute care hospital, OR

F. Less restrictive levels of care are unavailable for safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity,

2. At least one of the following criteria must be met:

A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.

B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated, OR

C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.

B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

C. Continued stay is not primarily due to a lack of external supports.

Residential Substance Use Disorders Treatment Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Residential Substance Use Disorders Treatment:

- › A facility that provides Residential Substance Use Disorders Treatment is either a stand-alone substance use facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose and that includes 7-day a week, 24 hour supervision and monitoring.
 - Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
 - Facilities that provide Residential Substance Use Disorders Treatment are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible psychiatrist or addictionologist who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - The program provides for the mental health and physical health needs of the individual.
 - A nurse is on-site 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.
 - A psychiatrist or addictionologist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and prescribe medications as clinically indicated.
- › Treatment is focused on stabilization and improvement of functioning and reintegration with family or significant others.
 - Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.
 - Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued treatment services at less-restrictive levels of care, as needed.
- › Residential treatment coverage is not based on a preset number of days.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › Residential treatment is not a substitute for a lack of available supportive living environment(s) in the community.
- › **Detoxification in Residential Substance Use Disorders Treatment:** *Some individuals who otherwise meet the Medical Necessity criteria for Residential Substance Use Disorders Treatment may also need a clinical withdrawal that is managed by appropriately trained staff that can provide 24 hour supervision, observation, and support. Such services are sometimes referred to as “Residential Detoxification” or “Social Detoxification”*
 - *Detoxification at this level of care is characterized by its emphasis on peer and social support rather than intensive medical and nursing care.*
 - *Residential Detoxification is only appropriate when substance use withdrawal symptoms are of moderate severity, such that an intensive medically monitored inpatient detoxification is not required.*
- **Detoxification in Residential Substance Use Disorders Treatment level of care is NOT appropriate if any of the following circumstances are present:**
 - *The individual does not meet the Medical Necessity criteria for Residential Substance Use Disorders Treatment.*
 - *Objective medical symptoms and/or a history that indicates a high level of risk for a severe alcohol and/or sedative, hypnotic withdrawal syndrome.*
 - *An opiate withdrawal syndrome that is of such severity that the individual is not capable of active participation in the residential treatment program.*
 - *An individual who is suffering from symptoms of a severe co-existing mental or physical disorder that is of such severity that the individual is not capable of active participation in the residential treatment program*
- *A need for initiation or continuation of detoxification and/ or symptoms associated with withdrawal or post-acute withdrawal should not be the primary criteria for admission or continued stay at substance residential level of care.*

Examples of services that typically do not meet criteria for Residential Substance Use Disorder Treatment:

- › There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as facilities that provide Residential Substance Use Disorders Treatment and that do not meet all of the above criteria. A few examples follow:
 - **Therapeutic Group Homes:** These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.
 - **Therapeutic (Boarding) Schools:** The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.

- **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** “At times state statute defines ‘boot camps’ or ‘wilderness therapy programs’ as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most of the ‘boot camps’ and ‘wilderness programs’ do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child’s care. Also, the Joint Commission nearly universally denies certification for these types of programs that fail to meet the quality of care guidelines for medically supervised care from licensed mental health professionals.” (6)
- **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration within the justice system or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or simply as respite or housing.
- **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

Admission Considerations for Residential Substance Use Disorders Treatment:

- › Within 72 hours prior to the request for admission, there has been a face-to-face evaluation with the individual and family/significant others by a licensed behavioral health clinician with training and experience in the assessment and treatment of individuals with substance use disorders and consistent with the age and problems of the individual. This assessment includes a clinically-based recommendation for the need for this level of care.
- › The admissions process should also include:
 - A documented current diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
 - Evaluation by a Board Certified/Board Eligible psychiatrist or addictionologist within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient. (or per relevant state regulatory and licensing standards)
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Notes:

- *Relapse should not be the sole criterion for managing an individual in a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and the family; the risk of danger/ harm to the individual or others; and the reason for the relapse.*
- *A need for initiation or continuation of detoxification and/ or symptoms associated with withdrawal or post-acute withdrawal should not be the primary criteria for admission or continued stay at substance use residential level of care.*

Expectations for Residential Substance Use Disorders Treatment:

- › A documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
- › Residential treatment should occur as close as possible to the home and community to which the individual will be discharged
 - If out-of-area placement is unavoidable, there must be consistent family involvement with the individual, and regular family therapy and discharge planning sessions, unless clinically contraindicated.
- › Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
 - Therapeutic passes may occur, when clinically indicated, as part of the transition and discharge planning process to allow opportunity to practice therapeutic skills/gains with the family.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **A Preliminary Treatment Plan** is completed within 48 hours of admission and a **Comprehensive Treatment Plan** is to be completed within 5 days that includes:
 - A clear focus on the issues leading to the admission and on the symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
 - Multidisciplinary assessments of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.

- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Establish specific, measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the individual.
- › **When there is a history of repeated relapses and/or multiple failed treatment episodes**, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:
 - Specifically addresses prior non-adherence and poor response to treatment
 - Includes elements that are likely to reduce the frequency and severity of future relapse.
 - Has the goal of maintaining abstinence.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Discharge planning** will start at the time of admission and include:
 - Coordination with family, outpatient providers, and community resources to facilitate a smooth transition back to home, family, work or school, and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments, with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Residential Substance Use Disorders Treatment

Criteria for Admission

1. **All of the following must be met:**
 - A. All elements of Medical Necessity must be met.
 - B. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
 - C. The individual's substance use disorder is pervasive and is significantly impairing functioning across multiple settings such as work, home, and in the community, and clearly demonstrates the need for 24 hour skilled psychiatric and nursing monitoring and intervention.
 - D. For individuals under 18 years, the individual's family is willing to commit to active regular treatment participation.
 - E. As a result of the interventions provided at this level of care, the symptoms and/or behaviors that led to the admission can be reasonably expected to show improvement such that the individual will be capable of returning to the community and to less restrictive levels of care

F. The individual is able to function with some independence, so as to be able to participate in structured activities in a group environment.

2. None of the following are present:

- A. Life-threatening symptoms of withdrawal.
- B. Current withdrawal symptoms that preclude active participation in treatment.
- C. Medical or psychiatric impairments that preclude active participation in treatment.

3. When there is a history of repeated relapses and/or multiple failed treatment episodes, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:

- Includes clear interventions specifically addressing prior non-adherence and poor response to treatment
- Includes clear interventions that are likely to reduce the frequency and severity of future relapse.
- Has the goal of maintaining abstinence.

AND

4. One or more of the following criteria must be met:

- A. The individual suffers from a severe, uncontrolled, co-occurring psychiatric illness or severe behavioral disturbance that interferes with his/her ability to successfully participate in a less restrictive level of care
- B. The individual's living environment is such that his/her ability to successfully achieve abstinence is seriously jeopardized by either:
 - i) A home environment that includes family/significant others that are actively opposed to the treatment efforts, or
 - ii) A home environment that includes family/significant others that are actively involved in their own substance abuse.
- C. The individual's social, family, or occupational functioning is severely impaired secondary to substance use such that most of his/her daily activities revolve around obtaining, using and recuperating from substance abuse,
- D. The individual has demonstrated a repeated inability to control his/her impulses to use illicit substances and is at imminent risk of causing (medical or behavioral) harm to self or others. This is of such severity that it requires 24 hour monitoring/support/intervention.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.

2. One or more of the following criteria must be met:

- A. The treatment provided is leading to measurable clinical improvements in the symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- B. If the treatment plan implemented is not leading to measurable clinical improvements in the symptoms and/or behaviors that led to this admission and a progression toward discharge from

the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.

- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Partial Hospital Substance Use Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Partial Hospital Substance Use Disorders Treatment provides a coordinated, intense, ambulatory, multi-disciplinary and acute short-term treatment for individuals who can maintain personal safety with support systems in the community.

- › Treatment provided in this setting is similar in nature and intensity to that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.
- › Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
 - "Partial hospitalization programs (PHP's) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu...
 - "PHP's may pursue one or both of the following major functions:
 - Acute Crisis Stabilization
 - Acute Symptom Reduction."(14)
- › Partial hospital programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.
- › An Individual in Partial Hospital Substance Use Disorders Treatment:
 - May present ongoing risk of harm to him/her or others, but is able to develop a plan to maintain safety in the community without 24 hour supervision.
 - Is having moderate-to-severe and acute substance use disorder symptoms that are compromising daily functioning with work, parenting, school, and/or with other essential activities of daily living.
 - Has the ability:
 - To make age-appropriate basic decisions for him/herself AND
 - To accept age-appropriate responsibility for his/her own actions and behavior.

Admission Considerations for Partial Hospital Substance Use Disorders

Treatment:

- › Within 72 hours prior to the request for admission, there has been a face-to-face assessment by a licensed behavioral health clinician with training and experience in the assessment and treatment of substance use disorders.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › The admissions process should also include:
 - A documented current diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
 - Evaluation by a Board Certified/Board Eligible psychiatrist or addictionologist within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - A medical assessment and physical examination within the first 72 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
 - Identification of family and/or community resources and family participation in treatment, unless contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Notes:

- *Relapse should not be the sole criterion for managing an individual in a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and the family; the risk of danger/ harm to the individual or others; and the reason for the relapse.*
- *A need for initiation or continuation of detoxification and/ or symptoms associated with withdrawal or post-acute withdrawal should not be the primary criteria for admission or continued stay at substance use partial hospital level of care.*

Expectations for Partial Hospital Substance Use Disorders Treatment:

- › A documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of acute distress/impairment
- › Individuals who are at this level of care are typically in a structured treatment program *5 days per week with a minimum of 20 hours of scheduled programming.*
- › All services offered must consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment.
- › **The individual is not considered a resident at the program.**
 - The individual lives in the community without the restrictions of a 24 hour supervised setting during non-program hours.
 - This level of care is only appropriate for individuals who are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

- Partial hospital programs are expected to give individuals fully unsupervised, unstructured hours each day to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
- During non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others, except as age-appropriate for children and adolescents.
- › Cigna does not cover boarding for Partial Hospital Programs, as this level of care is an ambulatory service.
- › For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 24 hours of admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- › The facility provides a structured program, which is staffed by licensed clinicians trained in the treatment of substance use disorders.
- › The attending psychiatrist or addictionologist is expected to assess individuals weekly or more frequently as needed.
- › During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board Eligible/Board Certified psychiatrist or addictionologist.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A clear focus on the issues leading to the admission and on the acute symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission.
 - Clear, objective and observable discharge criteria.
 - A discharge plan that includes coordination with community resources to allow a smooth transition to less restrictive levels of care, family integration, and continuation of the recovery process.
- > **When there is a history of repeated relapses and/or multiple failed treatment episodes**, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:
- Specifically addresses prior non-adherence and poor response to treatment.
 - Includes elements that are likely to reduce the frequency and severity of future relapse.
 - Has the goal of maintaining abstinence.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- > **Discharge Planning** will start at the time of admission and include:
- > Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
 - > Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
 - > Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Note: *This level of care should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.*

Medical Necessity Criteria – Partial Hospital Substance Use Disorders Treatment

Criteria for Admission

1. **None of the following are present:**
 - A. Life-threatening symptoms of withdrawal.
 - B. Current withdrawal symptoms that preclude active participation in treatment.
 - C. Medical or psychiatric impairments that preclude active participation in treatment.
2. **All of the following must be met:**
 - A. All elements of Medical Necessity must be met.

- B. The individual has a documented diagnosis of a moderate-to-severe and acute substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
 - C. **When there is a history of repeated relapses and/or multiple failed treatment episodes**, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:
 - i) Includes clear interventions specifically addressing prior non-adherence and poor response to treatment
 - ii) Includes clear interventions that are likely to reduce the frequency and severity of future relapse.
 - iii) Specifically addresses prior non-adherence and poor response to treatment.
3. **One or more of the following must be met:**
- A. **The individual is demonstrating significant acute impairments** in functioning secondary to a substance use disorder, as evidenced by both of the following:
 - i) **The individual is severely impaired** and is not able to complete essential daily social, family, school, and/or work activities AND
 - ii) **The individual is not able to employ sufficient coping skills** to compensate for this.

OR
 - B. The individual has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24 hour monitoring environment,

OR
 - C. The individual requires a structured program to manage acute substance use disorder symptoms that are seriously interfering with treatment of a potentially life-threatening medical condition that cannot be safely and effectively managed at a less restrictive level of care (e.g., pregnancy, uncontrolled diabetes).

OR
 - D. The individual requires a structured program to manage acute medical symptoms that are seriously interfering with treatment of a serious co-existing substance use disorder that cannot be safely and effectively managed at a less restrictive level of care.
4. **All of the following must be met:**
- A. The individual is mentally and emotionally capable to actively engage in the treatment program
 - B. The individual is able to live in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate for children and adolescents.
 - C. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
 - D. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
 - E. If there are medical issues, they can be safely managed in a partial hospital level of care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Substance Use Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Intensive Outpatient Substance Use Disorders Treatment provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety with support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

- › Facilities that provide Intensive Outpatient Substance Use Disorders Treatment programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.
- › An Individual in Intensive Outpatient Substance Use Disorders Treatment:
 - Has the ability:
 - To make basic decisions for him/herself AND
 - To accept responsibility for his/her own actions and behavior.
 - Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
 - Is not at imminent risk for serious bodily harm toward self or others.
 - Intensive Outpatient Substance Use Disorders Treatment is appropriate to consider for complex clinical situations that would otherwise result in the need for a more restrictive level of care.
- › The duration of treatment and frequency of attendance are re-evaluated and adjusted according to the individual severity of signs and symptoms.
- › Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- › This level of care can be the first level of care authorized, to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant returned to a less structured outpatient setting.

Note: *Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine*

Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.

Admission Considerations for Intensive Outpatient Substance Use Disorders Treatment

- › Within 72 hours prior to admission, there has been a face-to-face individual assessment by a licensed behavioral health clinician, with training and experience in the assessment and treatment of substance use disorders and consistent with the age and problems of the individual.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically indicated.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
 - Evaluation by a licensed behavioral health clinician with training and experience consistent with the age and problems of the individual within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Expectations for Intensive Outpatient Substance Use Disorders Treatment:

- › Individuals who are at this level of care are typically in a structured treatment program *3-4 hours per day, 3-5 days per week.*
- › **The individual is not considered a resident at the program.**
 - The individual lives in the community without the restrictions of a 24 hour supervised setting during non-program hours.
 - This level of care is only appropriate for individuals who are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
 - Intensive Outpatient Programs are expected to give individuals fully unsupervised, unstructured hours each day to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
 - During non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.
- › Cigna does not cover boarding for Intensive Outpatient Programs as this level of care is an ambulatory service.
- › For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 24 hours of

admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.

- › The facility provides a structured program, which is staffed by licensed clinicians with training and experience in the treatment of substance use disorders.
- › Individual therapy sessions occur, as clinically indicated.
- › A psychiatrist or addictionologist is available for consultation, as needed.
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
 - Clear, objective and observable discharge criteria.
 - A discharge plan that includes coordination with family and community resources to allow a smooth transition to outpatient services, family integration, and continuation of the recovery process.

When there is a history of repeated relapses and/or multiple failed treatment episodes, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:

- Specifically addresses prior non-adherence and poor response to treatment.
- Includes elements that are likely to reduce the frequency and severity of future relapse.
- Has the goal of maintaining abstinence.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.

- However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **Discharge Planning** will start at the time of admission and include:
- Coordination with family, outpatient providers, and community resources to allow a smooth transition to a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Intensive Outpatient Substance Use Disorders Treatment

Criteria for Admission

None of the following are present:

1. Life-threatening symptoms of withdrawal.
2. Current withdrawal symptoms that preclude active participation in treatment.
3. Medical or psychiatric impairments that preclude active participation in treatment.

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. **The individual is demonstrating difficulties in functioning** secondary to a substance use disorder to the extent that:
 - A. **The individual is mildly to moderately impaired** in his/her ability to complete routine daily social, family, school, and/or work activities, AND
 - B. **The individual is able to employ sufficient coping skills** to continue with most routine daily activities.
4. The individual is mentally and emotionally capable to actively engage in the treatment program
5. The individual is able to live in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate for children and adolescents.
6. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
7. The individual has a support system that includes family or significant others/guardians who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

8. If there are medical issues, they can be safely managed in an Intensive Outpatient Treatment level of care.
9. **When there is a history of repeated relapses and/or multiple failed treatment episodes**, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:
 - Includes clear interventions specifically addressing prior non-adherence and poor response to treatment.
 - Includes clear interventions that are likely to reduce the frequency and severity of future relapse.
 - Has the goal of maintaining abstinence.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.

2. One or more of the following criteria must be met:

- A. The treatment provided is leading to measurable clinical improvements in the mild-to moderate symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
- B. If the treatment plan implemented is not leading to measurable clinical improvements in the mild-to-moderate symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
- C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

- A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
- B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
- C. Continued stay is not primarily due to a lack of external supports.

Eating Disorders Treatment

SECTION V.

Acute Inpatient Eating Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Acute Inpatient Eating Disorders Treatment is utilized when the following care services are needed:

- › Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
- › Acute treatments to control behavior and symptoms requiring stabilization.
- › Acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others.
- › Daily monitoring of medication effects and side effects.
- › A contained environment for specific treatments that could not be safely done in a less-restrictive setting.

Admission Considerations for Acute Inpatient Eating Disorders Treatment:

- › Prior to admission, there has been a face-to-face evaluation by a licensed behavioral health clinician with training and experience in the assessment and treatment of eating disorders to determine if this level of care is medically necessary and clinically appropriate.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The medical evaluation should particularly focus on weight, cardiac status, metabolic status, vital signs, and relevant lab values.
- › The level of care determination should not be based on a single or limited number of physical parameters such as weight alone.
- › Acute Inpatient Eating Disorders Treatment should be driven by the severity of symptoms present, the level of risk to the patient, and the severity of physical and psychological complications that would require 24 hour medical management and monitoring.
- › Most individuals with uncomplicated Bulimia Nervosa or a Binge-Eating Disorder do not meet medical necessity criteria for this level of care unless there are:
 - Severe disabling symptoms that have not responded to a less intensive levels of care, and/or

- Serious concurrent general medical problems (e.g., metabolic abnormalities, hematemesis, vital sign changes, or the appearance of uncontrolled vomiting).

Expectations for Acute Inpatient Eating Disorders Treatment:

- › A documented current diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
- › Evaluation by a Board Certified/Board Eligible Psychiatrist within 24 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care.
- › Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist.
- › Physician follow-up occurs daily or more frequently as needed.
- › A medical assessment and physical examination is completed and indicated blood and urine specimens are obtained for laboratory analysis within 24 hours of admission.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › Within 48 hours of admission, outreach will be done with existing providers and family members to obtain needed history and clinical information, unless clinically contraindicated.
- › The facility will rapidly assess and address any urgent behavioral and/or physical issues.
- › Ongoing academic schooling is provided for children and adolescents to facilitate a transition back to the child's previous school setting.
- › Young children (12 years and younger) will be admitted to a unit exclusively for children.

Family Involvement – *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore, prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
- **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
- **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.

- Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation).
- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

› **Discharge Planning** will start at the time of admission and include:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
- Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Acute Inpatient Eating Disorders Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
3. **One or more of the following criteria must be met:**
 - A. The individual has medical instability with abnormalities in some or all vital signs: heart rate (less than 40 in adults or less than 50 in children/adolescents) temperature (less than 97 F), blood pressure (less than 90/60 mm Hg in adults or less than 80/50 for children/adolescents), orthostatic pulse increase (more than 20 beats per minute), orthostatic blood pressure decrease (more than 10-20 mm),
 - B. The individual has abnormal relevant lab values secondary to the Eating Disorder such as low serum glucose (less than 60 mg/dl), electrolyte imbalances, low potassium (less than 3.2 mEq/L), low phosphorus, or low magnesium,
 - C. The individual has significant medical symptoms secondary to the Eating Disorder such as evidence of dehydration, significantly impaired liver, kidney, or heart function; or poorly controlled diabetes needing acute stabilization,
 - D. The Individual has significant decrease in Ideal Body Weight, as indicated by one of the following:
 - i) A Body Mass Index (BMI) less than 16,

- ii) For children and Adolescents, a rapid, recent, continuing weight decline due to food refusal. Growth charts should be utilized for children and adolescents,
 - iii) BMI is greater than 16 and less than 30, AND there is evidence of one of the following:
 - a) Weight loss or fluctuation of two or more pounds per week,
 - b) Weight loss associated with medical instability unexplained by any other medical condition
- E. The individual's eating disorder symptoms require around the clock medical/nursing intervention for one or more of the following.
- i) For issues of imminent risk of harm to self or others,
 - ii) There is a need to provide immediate interruption of food restriction, excessive exercise, binging and purging, and/or use of laxatives/diet pills/diuretics,
 - iii) To avoid impending life threatening harm due to medical consequences,
 - iv) To avoid impending life threatening complications due to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes),
- F. In addition to a primary eating disorder that requires treatment at this level of care, there is a co-occurring psychiatric disorder and/or risk of self-harm requiring 24 hour medical /nursing intervention.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Residential Eating Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Residential Eating Disorders Treatment:

- › A facility that provides Residential Eating Disorders Treatment is either a stand-alone specialized mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose with 7 day per week, 24-hour supervision and monitoring.
 - Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
 - Facilities that provide Residential Eating Disorders Treatment are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible Psychiatrist with training and experience in the assessment and treatment of eating disorders who conducts a face-to-face interview with each individual within 48 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - The program provides for the mental health and physical health needs of the individual.
 - A nurse is on-site 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.
 - A psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and prescribe medications as clinically indicated.
- › Treatment is focused on stabilization and improvement of functioning and reintegration into the community.
 - Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued treatment services at less-restrictive levels of care, as needed.
 - Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.
 - Residential treatment coverage is not based on a preset number of days.

- The length of a standardized program such as a “30-Day Treatment Program” is not considered as a medically necessary reason for admission and/or continued stay at this level of care.
- › *Residential treatment is not a substitute for a lack of available supportive living environment(s) in the community.*
- › Examples of services that typically do not meet criteria for Residential Eating Disorder Treatment: There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Residential Eating Disorders Treatment facilities, or the equivalent, and that do not meet all the above criteria. A few examples follow:
 - **Therapeutic Group Homes:** These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.
 - **Therapeutic (Boarding) Schools:** The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.
 - **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** “At times state statute defines ‘boot camps’ or ‘wilderness therapy programs’ as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most of the ‘boot camps’ and ‘wilderness programs’ do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child’s care. Also, the Joint Commission nearly universally denies certification for these types of programs that fail to meet the quality of care guidelines for medically supervised care from licensed mental health professionals.” (6)
 - **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration within the justice system or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or simply as respite or housing.
 - **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

Admission Considerations for Residential Eating Disorders Treatment:

- › Within 72 hours prior of the request for admission, there has been a face-to-face assessment with the individual and family/significant others by a licensed mental health clinician with training and experience consistent with the age and problems of the individual.
- › This assessment includes a clinically-based recommendation for the need for this level of care and includes family/significant others as clinically appropriate.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.

- Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience in the assessment and treatment of eating disorders within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
- A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
- Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
- Discharge planning.

Expectations for Residential Eating Disorders Treatment:

- › Residential treatment should occur as close as possible to the home to which the individual will be discharged.
 - If out-of-area placement is unavoidable, there must be consistent family involvement with the individual and regular family therapy and discharge planning sessions, unless clinically contraindicated.
- › Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- › Ongoing academic schooling is provided for children and adolescents to facilitate a transition back to the child's previous school setting.
- › Young children (12 years and younger) will be admitted to a unit exclusively for children.
- › **Family Involvement** – *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore, prompt and timely involvement of family/significant others is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** - The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
 - Therapeutic passes may occur, when clinically indicated, as part of the transition and discharge planning process to allow opportunity to practice therapeutic skills/gains with the family.
- › **A Preliminary Treatment Plan** is completed within 48 hours of admission and a **Comprehensive Treatment Plan** is to be completed within 72 hours that includes:

- A clear focus on the issues leading to the admission and on the symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
- Multidisciplinary assessments of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.
- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition to a less restrictive treatment level of care, family integration, and continuation of the recovery process.
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- Realistic, specific, measurable, and achievable goals.
- This plan should:
 - Be developed jointly with the individual and family/significant others.
 - Include multidisciplinary assessments.
 - Establish measurable goals and objectives.
 - Include treatment modalities that are appropriate to the clinical needs of the patient.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

- › **Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.
 - Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Discharge planning** will start at the time of admission and include:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school, and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Residential Eating Disorders Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual is expressing willingness to actively participate in this level of care

3. The individual has a documented diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
4. If there are medical issues, they can be safely managed in a residential level of care.
5. The individual is able to function with some independence, participate in structured activities in a group environment.
6. As a result of the interventions provided at this level of care, the symptoms and/or behaviors that led to the admission can be reasonably expected to show improvement such that the individual will be capable of returning to the community and to less restrictive levels of care
7. For individuals under 18 years, the individual's family is willing to commit to active regular treatment participation.
8. There is evidence that a less restrictive level of care is not likely to provide safe and effective treatment.

One or more of the following criteria must be met:

1. Structure and supervision is needed at all meals to prevent restricting or bingeing-purging and the family/support system is unable to provide this level of monitoring at a less intensive level of care,
2. The individual's condition requires around the clock intervention to provide interruption of the food restriction, excessive exercise, bingeing, purging and/or use of laxatives/diet pills/diuretics, to avoid impending life threatening medical consequences or to avoid impending life threatening complications due to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes),
3. Along with a primary eating disorder that is requiring active treatment, there is a co-occurring psychiatric disorder or risk of self-harm requiring 24 hour supervision.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Partial Hospital Eating Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice;
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Partial Hospital Eating Disorders Treatment provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety with support systems in the community.

- › Treatment provided in this setting is similar in nature and intensity as that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.
- › Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
 - "Partial hospitalization programs (PHP's) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu...
 - "PHP's may pursue one or both of the following major functions:
 - Acute Crisis Stabilization
 - Acute Symptom Reduction." (14)
- › Partial Hospital Eating Disorders Treatment programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system
- › An Individual in Partial Hospital Eating Disorders Treatment:
 - May present ongoing risk of harm to him/her or others, but is able to develop a plan to maintain safety in the community without 24 hour supervision.
 - Is having moderate-to-severe and acute eating disorder symptoms that are compromising daily functioning with work, parenting, school, and/or with other activities of daily living.
 - Has the ability:
 - To make age-appropriate basic decisions for him/herself AND
 - To accept age-appropriate responsibility for his/her own actions.

Admission Considerations for Partial Hospital Eating Disorders Treatment:

- › Within 72 hours prior to the request for admission, there has been a face-to-face assessment with the individual and family by a licensed behavioral health clinician with training and experience in the assessment and treatment of eating disorders and with training and experience consistent with the age and problems of the individual.
- › This assessment includes a clinically-based recommendation for the need for this level of care.
- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
 - Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of the individual within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - A medical assessment and physical examination within the first 72 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Expectations for Partial Hospital Eating Disorders Treatment:

- › Individuals who are at this level of care are typically in a structured treatment program 5 days per week with a minimum of 20 hours of scheduled programming.
- › All services offered must consist of active treatment that specifically addresses the presenting problems of the individuals served and realistic goals that can be accomplished within the duration of treatment.
- › **The patient is not considered a resident at the program.**
 - The patient lives in the community without the restrictions of a 24 hour supervised setting during non-program hours.
 - This level of care is only appropriate for individuals who are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
 - Partial hospitalization programs are expected to give individuals fully unsupervised, unstructured hours each day to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
 - During non-program hours, an individual who is boarding at or near a facility must have the freedom each day, as age appropriate, to interact with the community independently, without being accompanied by staff or others, except as age appropriate for children and adolescents.
- › Cigna does not cover boarding for Partial Hospital Eating Disorders Treatment programs as this level of care is an ambulatory service.

- › The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.
- › During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board Eligible/Board Certified psychiatrist with training and experience in the evaluation and treatment of Eating Disorders.
- › **Family Involvement** – *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
 - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation.
 - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
 - The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
 - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
 - Clear, objective and observable discharge criteria.
 - A discharge plan that includes coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

- › **Discharge Planning** will start at the time of admission and include:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
 - Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Note: This level should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.

Medical Necessity Criteria – Partial Hospital Eating Disorders Treatment

Criteria for Admission

1. **All of the following must be met:**
 - A. All elements of Medical Necessity must be met.
 - B. The individual has a documented primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
2. **One or more of the following must be met:**
 - A. **The individual is demonstrating significant acute impairments** in functioning secondary to an eating disorder, as evidenced by both of the following:
 - i) **The individual is severely impaired** and is not able to complete essential daily social, family, school, and/or work activities AND
 - ii) **The individual is not able to employ sufficient coping skills** to compensate for this.
 - B. The individual has demonstrated an inability to maintain a healthy weight and/or medical stability without the frequency and intensity of structured interventions of the Eating Disorder Partial Hospital level of care.
 - C. The individual has documented evidence of repeated relapses, and inability to carry out treatment plan objectives in a treatment setting of less frequency and intensity than the Eating Disorder Partial Hospital level of care.
 - D. The individual cannot reduce incidents of purging in a treatment setting of less frequency and intensity than the Eating Disorder Partial Hospital level of care. The individual requires a high degree of structure for eating full meals and gaining weight.
 - E. The individual requires a structured program to manage acute eating disorder symptoms that are seriously interfering with treatment of a potentially life-threatening medical condition that cannot be safely and effectively managed at a less restrictive level of care (e.g., pregnancy, uncontrolled diabetes).
 - F. The individual requires a structured program to manage acute psychiatric symptoms that are seriously interfering with treatment of the Eating disorder that cannot be safely and effectively managed at a less restrictive level of care.
3. **All of the following must be met:**

- A. The individual is mentally and emotionally capable to actively engage in the treatment program and is able to comply with the requirements and structure of a partial hospital program, as demonstrated by ALL of the following:
 - i) The individual is expressing willingness to engage in treatment.
 - ii) The individual and the family are able to develop a safety plan with the provider that includes the ability to access emergency services so that a more intensive level of care is not required.
 - iii) The individual has a support system that includes individuals who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
- B. The individual is able to live in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate for children and adolescents.
- C. The individual is expressing willingness to engage in treatment.
- D. Current medical Issues can be safely managed in a partial hospital level of care.
- E. The individual has the skills to develop supports and/or become involved in a self-help support system.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Intensive Outpatient Eating Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Intensive Outpatient Eating Disorders Treatment provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety with support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

- › Intensive Outpatient Eating Disorders Treatment programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.
- › An Individual in Intensive Outpatient Eating Disorders Treatment:
 - Has the ability to make basic decisions for him/herself.
 - To accept responsibility for his/her own actions and behavior.
 - Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
 - Is not at imminent risk for serious bodily harm toward self or others.
 - Is appropriate to consider for complex clinical situations that would otherwise result in the need for a more restrictive level of care.
- › Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
- › This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant immediately returned to a less structured outpatient setting.

Note: Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.

Admission Considerations for Intensive Outpatient Eating Disorders Treatment:

- › Within 72 hours prior to admission,, there has been a face-to-face individual assessment with the individual and the family/significant others by a licensed mental health clinician, with experience

in the assessment of eating disorders and with training and experience consistent with the age and problems of the individual, to determine if this is a level of care that is medically necessary and clinically appropriate.

- › Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
- › The admissions process should also include:
 - A documented current diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders and evidence of moderate distress and impairment.
 - Evaluation by a licensed behavioral health clinician with training and experience in the assessment of eating disorders and consistent with the age and problems of the individual within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
 - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
 - Discharge planning.

Expectations for Intensive Outpatient Eating Disorders Treatment:

- › Individuals who are at this level of care are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
- › **The individual is not considered a resident at the program.**
 - The individual lives in the community without the restrictions of a 24 hour supervised setting during non-program hours, as age appropriate.
 - This level of care is only appropriate for individuals who are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
 - Intensive outpatient programs are expected to give individuals fully unsupervised, unstructured hours each day, as age appropriate, to function independently and to challenge themselves with exposure to many of the circumstances and/or stressors in the outside community that may have contributed to the admission.
 - During non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.
- › Cigna does not cover boarding for Intensive Outpatient programs as this level of care is an ambulatory service.
- › The facility provides a structured program, which is staffed by behavioral health clinicians who are trained and experienced in the treatment of eating disorders.
- › A psychiatrist is available for consultation, as needed.
- › **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
 - A focus on the issues leading to the admission.
 - Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, and living situation.

- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
- Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
- Clear, objective and observable discharge criteria.
- A discharge plan that includes coordination with family and community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.
- › **Family Involvement** – *The treatment should be family-centered with both the patient and the family included in all aspects of care.* Therefore prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
 - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
 - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
 - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
 - **Discharge planning.**
- › **Discharge Planning** will start at the time of admission and include:
- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Timely and clinically appropriate aftercare appointments.
 - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Intensive Outpatient Eating Disorders Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. Current medical issues can be safely managed in an intensive outpatient level of care.
4. **The individual is demonstrating difficulties in functioning** secondary to an eating disorder to the extent that:
 - A. **The individual has demonstrated an inability to maintain a healthy weight** and/or medical stability without frequent structured interventions of greater intensity/frequency than in routine outpatient treatment for eating disorders, OR
 - B. The individual has documented evidence of repeated relapses, and inability to carry out treatment plan objectives in routine outpatient treatment for eating disorders, OR
 - C. The individual cannot reduce incidents of purging in an unstructured setting. The individual requires some degree of structure for eating full meals and gaining weight but not as much as typically provided in a partial hospitalization program.
5. The individual is mentally and emotionally capable to actively engage in the treatment program.
6. The individual is able to live in the community without the restrictions of a 24 hour supervised setting, except as age-appropriate for children and adolescents.
7. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
8. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.

C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.

B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

C. Continued stay is not primarily due to a lack of external supports.

Behavioral Health Assessment and Treatment Procedures

SECTION VI.

Crisis Stabilization

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – 23-Hour Crisis Stabilization/Observation provides evaluation and intervention for individuals with acute symptoms of a behavioral health disorder when the clinical presentation does not immediately indicate the need for a higher level of care. It is considered when an individual presents with:

- › Acute symptoms of mental illness
- › Impairments caused by abuse of substances.
- › Behavior problems of a serious magnitude which cause immediate interference with the individual's ability to function at work, in school, within the family, or in social interactions.

Settings where service can be provided include:

- › **A hospital** – only when the facility is able to provide this service for no more than 23 hours.
- › **A Licensed Crisis Intervention Center** (either free-standing or attached to a hospital) that is able to provide the service for no more than 23 hours.
- › An outpatient clinical setting.

The ultimate setting is determined by the individual's clinical presentation, available resources, and by the facility's ability to begin active interventions within six hours of presentation.

Focus of the intervention:

- › Psychosocial factors relevant to the crisis.
- › Assessment for risk of harm to self or others.
- › Assessment of support networks.
- › A complete medical evaluation and basic medical procedures as indicated.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › Identification and mobilization of other available services.
- › Evaluation of the individual's willingness and reliability to participate in a mutually-acceptable treatment plan.

Note: This level of care is not appropriate when, based on clinical presentation or history, there is a strong likelihood that the individual will need the intensive structure of Acute Inpatient Treatment for more than 23 hours.

Description – Crisis Stabilization Unit (greater than 23 hours):

The use of Crisis Stabilization Unit (greater than 23 hours) may apply in those cases where a Crisis Stabilization Unit exists outside of an accredited hospital, but where 24-hour supervised and medically monitored services are available.

- › This level of care is for short-term crisis stabilization for those experiencing a mental health emergency.
- › The purpose is to prevent further decompensation that would result in an inpatient admission.
- › The typical length of stay is 1-7 days

This service provides:

- › The same type and intensity as a Crisis Stabilization Program offering intervention for 23 or less, but where 24-hour supervised and medically monitored services are available for those hours individuals needing:
 - Longer periods of observation to assess the crisis and determine risk.
 - Safe environment for more than 23 hours.
 - Psychiatric consultation – to occur ideally as soon as possible following admission, but definitely prior to discharge.
 - A complete medical evaluation and basic medical procedures as indicated.
 - Evaluation of family and social support systems that identify both opportunities and challenges, and a plan to address the latter.
 - Linkage and referrals to long-term services/community services.
 - An individualized treatment plan
 - Individual/family support for illness management
 - Medication management
 - May provide individual and group counseling
- › When medical services are not available on site, the program must be able to ensure that the individual will be linked to appropriate treatment and providers within a reasonable timeframe.

Focus of the Intervention

The goals of the intervention at this level of care are similar to the goals of a 23 hour-or less Crisis Stabilization program and include similar criteria:

- › Reduction of potential for harm to self or others and reduction of symptoms due to psychosis or substance use.
- › Ability to begin active interventions within 6 hours of admission by a mental health clinician
- › Identification and mobilization of available resources including support networks
- › The crisis stabilization intervention should focus on factors relevant to the crisis.
- › Appropriate Interventions include assessment of support networks, identification and assessment of available services, mobilization of those services, and an estimate of the individual's ability to access services and participate in the treatment plan.

Note: This level of care is not appropriate for an individual who, by clinical presentation or history, requires the intensive structure of Acute Inpatient Treatment for safety and stabilization.

The facility setting for a crisis stabilization bed, whether less than or greater than 23-hours, is within a unit that provides around-the-clock nursing and/or mental health staff supervision and continuous observation and control of behaviors to insure the safety of the individual and/or others.

Description – Outpatient Crisis Stabilization:

Outpatient Crisis Stabilization occurs as an ambulatory session. The services provided are rapid with immediate evaluation and triage to avoid further decrease in level of functioning and/or acute hospitalization. The services are intensified as needed and are available 24 hours a day, seven days per week.

This service provides:

- › Assessments to determine risk of harm to self or others and/or determine need for secure environment.
- › Evaluation for medical emergency and ability to safely transport to medical facility if necessary.
- › Intervention in any one of a number of settings including outpatient therapy office, facility-based outpatient department, or in the home of an individual with safety of all parties a primary concern.

Focus of the Intervention

- › Psychosocial factors relevant to the crisis.
- › Assessment for risk of harm to self or others.
- › Assessment of support networks.
- › Identification and mobilization of other available services.
- › Evaluation of the individual's willingness and reliability to access and participate in a mutually-acceptable treatment plan.
- › Development of a short-term, evidence-based treatment plan than includes a family or support system evaluation or therapy session.
- › Plan for follow-up that includes collaboration with family, the individual's psychiatrist, other mental health providers, the individual's primary care physician, and/or other community resources as appropriate.

Note: This level of care does not include crisis stabilization services provided within an emergency room setting. Emergency Room services are generally covered by an individual's medical health plan benefits.

Medical Necessity Criteria – Crisis Stabilization

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The individual is expressing suicidal ideation, and/or hopelessness and helplessness likely to lead to self-injury, which must continue to be evaluated for severity and lethality. Because of lack of more immediately available support systems, this cannot be evaluated in a less restrictive setting,

- B. The individual is threatening harm to others or has acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation. This evaluation includes attempting to discern the etiology of such behaviors, especially if suspected to be chemically or organically induced,
- C. The individual is presenting with significant emotional and/or thought process disturbances which interfere with his/her judgment so as to seriously endanger the individual if not evaluated and stabilized on an emergency basis,
- D. The individual is showing severe signs of an acute stress reaction to a recent destabilizing event that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment. In addition, there is a need for a time-limited intervention to allow time for mobilization of additional resources and supports,
- E. The individual is in current treatment but the nature of the individual's course of illness is one characterized with recurrent presentations of self-injury or impaired thinking that responds rapidly to structured interventions. This level of care should only be considered when support systems and/or the previously designed crisis plan of the individual and his/her therapist have not been sufficient and the likelihood for further deterioration is high,
- F. The individual is presenting with intoxication that causes significant emotional, behavioral, medical, or thought process disturbance that interfere with his/her judgment so as to seriously endanger the individual if not monitored and evaluated for the need of ambulatory or inpatient detoxification.

Criteria for Continued Stay in Crisis Stabilization (greater than 23 hours):

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
 - A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
 - B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
 - C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
 - A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
 - B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
 - C. Continued stay is not primarily due to a lack of external supports.

Electroconvulsive Therapy (ECT)

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Electroconvulsive Therapy (ECT)

- › ECT is most often used to treat severe depression that fails to respond to medications or for individuals who are unable to tolerate the side effects associated with the medications.
- › ECT may be the treatment of choice
 - When there is a need for rapid stabilization for individuals who are at acute risk of harm due to severe agitation, delusions, suicidality, not eating or drinking. OR
 - For individuals with acute catatonia (a potentially life threatening trance-like state). OR
 - For stabilization of bipolar illness during extreme episodes of mania or depression and
 - To halt psychotic episodes associated with schizophrenia.

Note: This treatment may be administered on either an outpatient or inpatient basis.

Treatment Considerations for Electroconvulsive Therapy (ECT):

- › The severity of the psychiatric illness requires a rapid, definitive response.
- › The risk of ECT is less than the risks of other treatments.
- › There is a history of good response to ECT or poor response to medication in previous episodes of illness; or
- › The individual or legal representative, having discussed all alternative treatments, and being aware of and able to comprehend the risks and potential benefits of ECT, chooses ECT as his or her preferred treatment.
- › If the individual receiving ECT has a severe mental health disorder that requires Acute Inpatient Mental Health Treatment, the individual may then continue this treatment on an outpatient basis once stabilized to a point that 24 hour inpatient care is no longer a medical necessity.
- › Inpatient hospitalization may also be indicated for the initial few treatments for individuals with co-existing medical conditions that may seriously increase the risk of the procedure.
- › For most individuals, ECT is generally safe and effective on an outpatient basis when there is no medical necessity for more restrictive levels of care.

Expectations for Electroconvulsive Therapy (ECT):

The initiation of ECT is preceded by certain assessments and procedures:

- › A psychiatric evaluation that establishes that the diagnostic criteria are met for a condition that evidence has shown to be likely to positively respond to ECT.
- › A medical assessment to evaluate for any medical conditions that might increase the risks associated with ECT or anesthesia, as well as an evaluation by a qualified nurse anesthetist or anesthesiologist to determine if there are any conditions that may indicate a need for special precautions.
- › All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- › Education of the individual and family about the procedure that includes disclosure of potential risks and benefits and that results in written, informed consent by the individual or legal guardian, with the understanding that such consent may be withdrawn at any time.
- › The ECT procedure is administered by a psychiatrist who has participated in ongoing continuing education on ECT and who maintains all legally-required certifications.
- › An assessment of currently prescribed medications has been completed, and if the individual is continuing to take certain medications that might possibly negatively impact the procedure (e.g., theophylline, lithium, benzodiazepines, and/or anticonvulsants), there is documentation of the clinical reasons for continuation of these medications.

Note: If there is evidence of any of the following medical conditions, there needs to be documented evidence that the risks and benefits of ECT vs. other forms of treatment vs. no further treatment have been thoroughly considered and reviewed with the individual or guardian, and that the individual's condition requires a rapid, definitive response:

- › Unstable or severe cardiovascular disease
- › Aneurysm or arteriovenous malformation
- › Recent stroke
- › Severe lung disease
- › American Society of Anesthesiology physical status classification level Four or Five.

Medical Necessity Criteria – Electroconvulsive Therapy (ECT)

Criteria for Initiation of Treatment

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. **One or more of the following criteria must be met:**
 - A. The individual has a diagnosis of Major Depression, moderate or severe, or Mania, AND
 - i) Is resistant to treatment with medications, as evidenced by a lack of response to trials of at least three medications with adequate dose, duration and compliance to meet an expectation of improvement, OR
 - ii) Is intolerant of the side effects or adverse effects of psychopharmacologic agents, or is unable to take such agents due to drug interactions with a medically necessary medication deemed to be less likely or less severe with ECT, OR

- iii) Experiences deterioration of a mental health condition that creates a need for a rapid, definitive response to ensure the safety of the individual, OR
 - iv) Is experiencing a high degree of symptom severity and functional impairment.
OR
 - v) Has a history of favorable response to ECT
- B. The individual has a diagnosis of a psychotic disorder with (one of the following):
- i) Abrupt or recent onset of psychotic symptoms, OR
 - ii) Catatonia, OR
 - iii) A history of favorable response to ECT, OR
 - iv) Deterioration of a psychiatric condition that creates a need for a rapid, definitive response to ensure the safety of the individual, OR
 - v) Is experiencing a high degree of symptom severity and functional impairment.

3. All of the following must be met:

- A. A medical evaluation has been completed to assess potential risks associated with ECT.
- B. Risks and potential benefits of ECT have been explained and understood by the individual or guardian, and written, signed, informed consent has been obtained.
- C. Where applicable state laws require it, a second opinion consultation has been completed. Second opinion consultations should also be considered for women who are pregnant or for children/adolescents under age 18.
- D. There is no evidence of increased intracranial pressure (most commonly due to an inflammatory condition in or around the brain or spinal cord).

Criteria for Continued Treatment Course of Electroconvulsive Therapy

1. All of the following must be met:

- A. The initial course of treatment consists of two to three treatments per week, generally on non-consecutive days. (Note: the frequency of treatments may be reduced if delirium or severe cognitive dysfunction occurs).
- B. The number of treatments is a function of the individual's response, but should be in the range of 6 to 12 but not to exceed 20 sessions.
- C. If there is no clinical improvement after 8-10 sessions, the potential benefits of continued ECT should be reassessed by the Attending Physician.

Continuation ECT (continuation of treatment for 6 months at intervals of 1 week or longer) is indicated if both of the following are met:

- A. The individual has responded well to ECT.
- B. Interval psychiatric and medical evaluations are completed prior to each treatment,
- C. Frequency of sessions is at the minimum which sustains remission.
- D. Continued need for Continuation ECT is reassessed every month.

- E. Clinical treatment plans and consents are updated every month.

Maintenance ECT (continuation of treatment for longer than 6 months at intervals of 2 weeks or longer) is indicated if all of the following are met:

- A. The individual has responded well to ECT.
- B. Interval psychiatric and medical evaluations are completed prior to each treatment.
- C. Frequency of sessions is at the minimum which sustains remission.
- D. Continued need for Maintenance ECT is reassessed every six months.
- E. Clinical treatment plans and consents are updated every six months.

Psychological/Neuropsychological Testing

Note: *Benefit coverage for Psychological/Neuropsychological Testing varies under many Cigna Behavioral Health benefit plans, and may be governed by federal and/or state mandates, and subject to Cigna's Coverage Positions. Please refer to the applicable benefit plan document and Coverage Positions to determine benefit availability and the terms and conditions of coverage.*

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- › In accordance with the generally accepted standards of medical practice,
- › Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- › Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Description – Psychological/Neuropsychological Testing is the use of one or more standardized measurements, instruments or procedures to assess intellectual/cognitive ability, psychopathology, psychiatric symptomatology, personality, interpersonal processes, behavioral functioning, and/or adaptive skills.

- › May be used to guide differential diagnosis in the treatment of psychiatric disorders and to provide treatment recommendations.
- › The use of validated psychological testing instruments is considered adjunctive to other assessment tools that may include a face-to-face clinical interview, information gathering and review use of behavioral rating scales, consultation with collateral sources, and the individual's history.
- › Psychological testing may be an appropriate adjunctive intervention when its use is expected to have a unique, specific, and direct impact on treatment outcome.

Exclusion:

- › **Educational testing** is not considered a medically necessary service under the behavioral health benefits.
 - Educational testing is the use of psychological tests for educational purposes (e.g., to rule out a learning disability, determine learning style, and/or assess academic achievement), to provide support for an academic accommodations request, or for vocational purposes.
 - Parents of children looking for educational testing are encouraged to check with their public school district for resources.

Psychological Testing In Alcohol and Drug Treatment

The individual's compromised cognitive functioning often confounds the results of psychological testing in the context of early treatment for alcohol and drug dependence. Therefore, there should be a minimum of 30 days abstinence prior to the administration of testing for a mood disorder, and a minimum of 90 days abstinence for the assessment of cognitive functioning/impairment.

Expectations for Psychological/Neuropsychological Testing:

- › **Psychological testing** is to be conducted by a licensed psychologist (Ph.D., Psy.D. or Ed.D.).
- › **Neuropsychological testing** is to be conducted by a licensed doctoral level psychologist (Ph.D., Psy.D or Ed.D.) who has specialized training in the administration, scoring, and interpretation of neuropsychological instruments.
- › Testing by a psychometrist is allowed when the psychometrist has received appropriate training and is working under the direct supervision of a licensed psychologist/neuropsychologist.
- › When a psychometrist/psychological assistant are used, the psychologist/neuropsychologist must conduct the clinical interview and design the test battery before the psychometrist begins to administer any tests.
- › When administration of psychological/neuropsychological testing is delegated to a psychometrist or psychological assistant, the report must be signed by the fully licensed psychologist or neuropsychologist who is responsible for the interpretation of test results.

Note: Psychological testing results for inpatient cases should be reported (at least informally) within 24 hours and for outpatient cases should be reported within one week.

Medical Necessity Criteria – Psychological/Neuropsychological Testing

All of the following must be met:

1. Psychological/Neuropsychological Testing may be clinically appropriate when the administration of such testing is expected to offer unique, specific and direct information regarding the development or monitoring of the treatment plan
2. **One or more of the following criteria must be met:**
 - A. A diagnosis cannot be made with information derived from a thorough clinical interview, behavioral observation, consultation with collateral sources of information, and a review of history.
 - B. Development of a treatment plan would be ineffective and/or inefficient without information that can only be obtained by psychological testing.
 - C. The individual has undergone a course of psychological or psychiatric treatment and the response is not as expected from the treatment plan.
 - D. To assist with the differential diagnosis of a psychiatric versus neurological or other medical diagnosis that may be associated with psychiatric symptoms.

Psychological/Neuropsychological Testing is generally NOT considered medically necessary when one (or more) of the following are present:

1. Other sources of the same information are available (e.g., clinical interview, behavioral observations or review of individual's history), OR
2. The diagnosis appears clear without testing (testing is not required to "validate" a diagnosis), OR
3. The results of testing would have no significant effect on the design and implementation of a treatment plan for a psychological disorder, OR
4. A diagnosis has already been rendered, and the individual has shown improvement via the treatment plan already in place. (e.g., individual's MD is currently prescribing medication for ADHD but wants testing to "validate" the diagnosis), OR

5. The rationale for testing is vague, or the diagnostic question lacks specificity (e.g., “*Parents want to know what’s going on,*” “*The pediatrician is asking for it,*” “*Just want to get a bigger picture.*”), OR
6. Testing appears to be primarily for educational purposes (e.g., to rule out a learning disability, determine learning style and/or assess academic achievement), to provide support for an academic “accommodations” request, or for vocational purposes, OR
7. The individual has a history of problematic drug or alcohol use/dependence and has not been able to demonstrate a sustained period of sobriety for 30 days prior to testing for a mood disorder/90 days when assessing cognitive functioning, OR
8. Testing is requested primarily for legal purposes including custody evaluations, parenting assessments, or other court or government ordered/requested testing AND the request does not otherwise meet the criteria for testing, OR
9. Testing is requested primarily for work-related concerns/return to work AND the request does not otherwise meet the criteria for testing, OR
10. Results of testing are used primarily for admission to a treatment facility AND the individual would not otherwise meet criteria for testing, OR
11. The requested test battery would not answer the referral question, OR
12. There is concern about the specific tests being requested:
 - A. The requested tests are outdated, OR
 - B. The reliability and validity for the requested tests are not established, OR
 - C. Appropriate normative data are not available for the requested tests.

References

References:

General Psychiatry

- 1) American Psychiatric Association Practice Guidelines, American Psychiatric Association Publishing, Arlington, VA, 2003-2014. <http://psychiatryonline.org/guidelines.aspx>
- 2) Behavioral Health Levels of Care, Milliman Care Guidelines®, 20th Edition, Seattle, WA, MCG Health, LLC, 2016.
- 3) American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May 2013.
- 4) American Psychiatric Association: Practice Guidelines for the Psychiatric Evaluation of Adults, 3rd Edition. Arlington, VA, American Psychiatric Publishing, 2016.

Child and Adolescent Psychiatry

- 5) Practice Parameters, The American Academy of Child and Adolescent Psychiatry, Washington, DC, http://www.aacap.org/cs/clinical_care_quality_improvement/practice_parameters
- 6) Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, American Academy of Child and Adolescent Psychiatry, June 2010.
- 7) Winters, N.C. & Pumariega, A., The Work Group on Community-Based Systems of Care, the Committee on Community Child and Adolescent Psychiatry, and the Work Group on Quality Issues, Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care, J. Am. Acad. Child Adolesc. Psychiatry, 2007;46(2):284-299.
- 8) TRICARE/CHAMPUS standards for Residential Treatment Centers (RTCs) Serving Children and Adolescents, TRICARE Reimbursement Manual 6010.57-M, Feb. 12,2008, Chapter 11, Addendum H.
- 9) Bukstein, O.G. and the Work Group on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Substance Use Disorders, J. Am. Acad. Child Adolesc. Psychiatry, 2005;44(6):609–621
- 10) Lock, J. & La Via, M.C., and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders, J Am Acad Child Adolesc Psychiatry 2015;54(5):412–425.

- 11) Sachs, M. and Madaan, V., Electroconvulsive Therapy in Children and Adolescents: Brief Overview and Ethical Issues, Sponsored by AACAP Ethics Committee, January, 2012.

Residential Treatment

- 12) Psychiatric Residential Treatment Facilities (PRTF) Clarification, Center for Medicaid and State Operations/Survey and Certification Group, Ref: S&C-07-15, February 16, 2007.
- 13) Preauthorization Requirements for Residential Treatment Center Care, TRICARE Policy Manual 6010.54-M, August 1, 2002, Chapter 7, Section 3.4.State Regulation of Residential Facilities for Adults with Mental Illness, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, www.samhsa.gov

See also (6), (8)

Partial Hospital Programs and Intensive Outpatient Programs

- 14) Standards & Guidelines for Partial Hospitalization Programs and Intensive Outpatient Programs, Fifth Edition, Association for Ambulatory Behavioral Healthcare (AABH), 2012
- 15) Definition of Partial Hospitalization. The National Association of Private Psychiatric Hospitals and the American Association for Partial Hospitalization, *Psychiatric Hosp.* 21(2):89-90, 1990
- 16) Outpatient Hospital Psychiatric Services, Medicare Benefit Policy Manual, Chapter 6, Section 70 - Hospital Services Covered Under Part B, A3-3112.7, HO-230.5 (Rev. 157, 06-08-12)
- 17) Medicare Hospital Manual, Section 230.7, Outpatient Partial Hospitalization Programs (PHP), Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), 2000 Clinical Issues in Intensive Outpatient Treatment. (Treatment Improvement Protocol (TIP) Series, No. 47). 2006. <http://www.ncbi.nlm.nih.gov/books/NBK64093/>

Substance Use Disorders

- 18) Practice Guidelines for the Treatment of Patients with Substance Use Disorders, American Psychiatric Association Publishing, Arlington, VA, 2006
- 19) The ASAM Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, American Society of Addiction Medicine, Inc, Chevy Chase, MD, 2013.
- 20) Texas Commission on Alcohol and Drug Abuse (TCADA) Guidelines, Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, Texas Administrative Code, Title 28, Part 1, Chapter 3, Subchapter HH, 2011.
- 21) SAMHSA/CSAT Treatment Improvement Protocol (TIP) Series. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1993-.
<http://www.ncbi.nlm.nih.gov/books/NBK82999/>
- i) Clinical Issues in Intensive Outpatient Treatment. (Treatment Improvement Protocol (TIP) Series, No. 47). 2006. <http://www.ncbi.nlm.nih.gov/books/NBK64093/>
 - ii) Detoxification and Substance Abuse Treatment. (Treatment Improvement Protocol (TIP) Series, No. 45). 2006. <http://www.ncbi.nlm.nih.gov/books/NBK64115/>
 - iii) Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. (Treatment Improvement Protocol (TIP) Series, No. 43). 2006. <http://www.ncbi.nlm.nih.gov/books/NBK64164/>

- iv) Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. (Treatment Improvement Protocol (TIP) Series, No. 40). 2004.
<http://www.ncbi.nlm.nih.gov/books/NBK64245/>
- v) Brief Interventions and Brief Therapies for Substance Abuse. (Treatment Improvement Protocol (TIP) Series, No. 34) 1999.
- vi) <http://www.ncbi.nlm.nih.gov/books/NBK64947/>

See also (9)

Eating Disorders

- 22) Practice Guidelines for the Treatment of Psychiatric Disorders, Treatment of Patients with Eating Disorders, Third Edition, American Psychiatric Association Publishing, 2010.
- 23) Lock, J. & La Via, M.C., and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders, J Am Acad Child Adolesc Psychiatry 2015;54(5):412–425.
- 24) National Institute for Clinical Excellence, Eating Disorders, Clinical Guide 9, January 2004.
- 25) American Academy of Family Physicians, Diagnosis of Eating Disorder in Primary Care, Table 6, Level of Care Criteria for patients with eating disorders, 2003.

See also (10)

Autistic Spectrum Disorders

- 26) Volkmar F, Siegel M. et al, and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autistic Spectrum Disorder, J Am Acad Child Adolesc Psychiatry. 2014; 53:237-257.
- 27) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, Second Edition, Behavior Analyst Certification Board, Inc. (BACB), 2014
http://bacb.com/wp-content/uploads/2015/07/ABA_Guidelines_for_ASD.pdf.
- 28) Warren Z, Taylor JL, McPheeters ML, Worley K, Veenstra-Vander Weele J., Future Research Needs: Interventions for Adolescents and Young Adults With Autism Spectrum Disorders. Future Research Needs Paper No. 20 (Prepared by Vanderbilt Evidence-based Practice Center under Contract No. 290-2007-10065-I). AHRQ Publication No. 12-EHC129-EF. Rockville, MD: Agency for Healthcare Research and Quality. September 2012. www.effectivehealthcare.ahrq.gov/reports/final.cfm

Electroconvulsive Therapy

- 29) Practice Parameter for Use of Electroconvulsive Therapy with Adolescents, AACAP Official Action, J. Am. Acad. Child Adolesc. Psychiatry, 2004; 43(12):1521–1539.
- 30) Sachs M. and Madaan V., Electroconvulsive Therapy in Children and Adolescents: Brief Overview and Ethical Issues, Sponsored by AACAP Ethics Committee, January, 2012.

See also (11)

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