Clinical UM Guideline

Subject:	Psychosocial Rehabilitation Services		
Guideline #:	CG-BEH-12	**Publish Date:**	04/25/2018
Status:	Reviewed	**Last Review Date:**	03/22/2018

Description

This document addresses psychosocial rehabilitation services (PRS). The medical necessity criteria outlined for PRS includes two categories: Severity of Illness and Continued Stay. Severity of Illness criteria includes descriptions of the member's condition and circumstances. For continued authorization of the requested service, Continued Stay criteria must be met, along with Severity of Illness criteria.

PRS are programs provided to groups of individuals in a nonresidential setting for 2 or more consecutive hours per day. PRS includes assessment, education to teach the member about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. Services are more intense than traditional psychiatric services.

Members in PRS may also be considered for other services as consistent with medical necessity.

Note: Please see the following related document(s) for additional information:

- CG-BEH-03 Psychiatric Disorder Treatment
- CG-BEH-09 Assertive Community Treatment
- CG-BEH-10 Basic Skills Training/Social Skills Training
- CG-BEH-11 Mental Health Support Services
- CG-BEH-13 Targeted Case Management

Clinical Indications

Medically Necessary:

Severity of Illness

Psychosocial rehabilitation services are considered **medically necessary** when **all** of the following are present:

A. The member experiences symptoms that meet the diagnostic criteria for a diagnosis from Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or International Classification of Diseases (ICD) for psychiatric outpatient treatment covered by the member's plan; **and**
B. Significant cognitive and behavioral impairments that impede the member's ability to live successfully in the community and are consistent with the DSM-5/ICD diagnosis listed, and these impairments are likely to improve with treatment. Impairments can include long-term or repeated psychiatric hospitalizations, difficulties in daily living, inability to function without intensive intervention, or limited to nonexistent support system; **and**
C. Interventions will focus on the presenting symptoms and complaints that have led to a decrease in the member's cognitive and behavioral functioning; **and**
D. A well-defined clinical rationale is documented that explains why the member would benefit from psychosocial rehabilitation consistent with their DSM-5/ICD diagnosis; **and**

E. The Member demonstrates motivation for treatment and is capable of benefiting from psychosocial rehabilitation services.

Continued Stay Criteria

Continued authorization of psychosocial rehabilitation services is considered **medically necessary** when **all** of A-E and F or G are present:

A. The member continues to meet Severity of Illness criteria; **and**
B. Documentation of member's participation and engagement in services; **and**
C. The goals of psychosocial rehabilitation services are not primarily for providing support; targets are not primarily functioning that is chronic and not likely to improve with the type of training being used, or primarily self-improvement; **and**
D. Functional impairment of at least moderate degree as evidenced by report of specific domains are still present related to the DSM-5/ICD diagnosis listed and likely to improve with continued training; **and**
E. Skills have not been acquired where sustained improvement is not likely, and the purpose of continued training is to prevent relapse or maintain previous achieved progress; **and**
F. Progress with the targeted functioning is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment, improving severity of functional impairment, and continued progress is expected for the targeted skills with the service approach being used; **or**
G. If progress is not documented, either diagnosis has been re-evaluated and changed if appropriate, medication has been re-evaluated and changed if indicated, or psychosocial rehabilitation services and treatment approach has been re-evaluated and changed if appropriate to include new goals/targets.

Not Medically Necessary:

Psychosocial rehabilitation services are considered **not medically necessary** when the above criteria are not met.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Note: The following list of procedure codes are examples only and may not represent all codes being used for psychosocial rehabilitation services. Please contact the member's plan for applicable coding conventions as these may vary.

HCPCS

H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem

ICD-10 Diagnosis

	For the following diagnoses, including but not limited to:
F01.50-F99	Mental, behavioral, and neurodevelopmental disorders

Discussion/General Information

PRS is sustained treatment that intends to restore a relatively full integration of members suffering from severe persistent mental illness into the community. Services are planned based on individual needs and can include support for medication adherence, treatment of substance abuse, therapy to enhance social and interpersonal skills, family participation and involvement in community activities. Improvement as the result of PRS may be exemplified by achieving member goals, improved social skills, decreased illness symptoms, improved quality of life and obtaining employment or successful school attendance. Randomized trials (RCT's) (Gigantesco, 2006; Shern, 2000; Swildens, 2011) and follow-up studies have not demonstrated consistent impact of PRS on the noted outcome variables with the most consistent finding being the accomplishment of member goals, a critical element in person-centered care.

Individuals suffering from chronic mental illness can benefit from services intended to restore function. A debilitating aspect of serious mental illness or serious emotional disorders is isolation from the larger community as the result of illness symptoms.

PRS should not be primarily for the avoidance of incarceration of the member or to satisfy a programmatic length of stay (refers to a predetermined number of days or visits for a program's length instead of an individualized determination of how long a member needs to be in that program). There should be a reasonable expectation that the member's illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the member's illness.

Standard components of PRS include:

- Assessment
- Education regarding mental health diagnosis
- Education regarding appropriate medications
- Relapse prevention
- Independent living skills
- Social and interpersonal skills

Standard outcomes of PRS include:

- Improved learning and application of knowledge
- Improved communication
- Improved mobility
- Improved self-care
- Improved domestic life
- Improved interpersonal interactions and relationships
- Improved communication and social life
- Improved support and relationships

Effective provision of PRS is built on a complete written assessment that identifies and documents the needs for PRS. A person-centered plan should be created that documents goals, objectives and criteria for discharge from PRS in a manner that reflects member goals, DSM-5/ICD diagnoses listed and the functional assessment. The planning process should be reviewed with the member every 3 months and rewritten no less often than annually. The services performed should teach the member about medication management and adherence when medications are prescribed, and if not, the reason and education addressing the lack of medication provided needs to be documented. Training addressing substance use and dependence should be provided when a diagnosis of substance use disorder is present. Opportunities are to be provided for the development of independent living skills and enhancement of social and interpersonal skills. The member's primary care

provider or equivalent is to be notified of provision of PRS services, and collaboration on prioritizing treatment should occur. Coordination of care with other clinicians providing care to the member or family members, including psychiatrist/therapist is to be documented. Family participation in treatment should be documented unless there is a contraindication to such participation. If a contraindication exists, rationale for lack of family participation is necessary. Community/natural supports and resources are to be identified and utilized. Skills training should include the development of and communication with support systems, such as community/natural supports, school/work, self-help or diagnosis specific support groups, spiritual/religious, and community recreational activities. Treatment should not duplicate other services being provided for the same reasons/diagnoses. Services must be provided at the frequency and intensity needs of the member, but are not to exceed limits specified in the member's benefit plan.

Definitions

Outpatient treatment: A level of care in which a mental health professional licensed to practice independently provides care to individuals in an outpatient setting, whether to the Member individually, in family therapy, or in a group modality.

Psychosocial rehabilitation services (PRS): An especially intense type of outpatient care consisting of sustained treatment that intends to restore a relatively full integration into the community, exemplified by an ability to work or attend school. Services are planned based on individual needs and can include support for medication adherence, treatment of substance abuse, therapy to enhance social and interpersonal skills, family participation and involvement in community activities.

Severe Mental Illness (also known as serious and persistent mental illness): A mental, behavioral or emotional disorder according to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, in members 18 years and older, that results in functional impairment which substantially interferes with or limits one or more major life activities (e.g., maintaining interpersonal relationships, activities of daily living, self-care, employment, recreation) that have occurred within the last year. All of these disorders may have acute episodes as part of the chronic course of the disorder. An organization may also use its state's definition or the definition of another appropriate regulatory authority (SAMHSA, 2016).

References

Peer Reviewed Publications:

1. Bartels SJ, Pratt SI. Psychosocial rehabilitation and quality of life for older adults with serious mental illness: recent findings and future research directions. Curr Opin Psychiatry. 2009; 22(4):381-385.
2. Bowie CR, McGurk SR, Mausbach B, et al. Combined cognitive remediation and functional skills training for schizophrenia: effects on cognition, functional competence, and real-world behavior. Am J Psychiatry. 2012; 169(7):710-718.
3. Gigantesco A, Vittorielli M, Pioli R, et al. The VADO approach in psychiatric rehabilitation: a randomized controlled trial. Psychiatr Serv. 2006; 57(12):1778-1783.
4. Kurtz MM, Mueser KT. A meta-analysis of controlled research on social skills training for schizophrenia. J Consult Clin Psychol. 2008; 76(3):491-504.
5. Shern DL, Tsemberis S, Anthony W, et al. Serving street-dwelling individuals with psychiatric disabilities: outcomes of a psychiatric rehabilitation clinical trial. Am J Public Health. 2000; 90(12):1873-1878.
6. Svedberg P, Svensson B, Hansson L, Jormfeldt H. A 2-year follow-up study of people with severe mental illness involved in psychosocial rehabilitation. Nord J Psychiatry. 2014; 68(6):401-408.

7. Swildens W, van Busschbach JT, Michon H, et al. Effectively working on rehabilitation goals: 24-month outcome of a randomized controlled trial of the Boston psychiatric rehabilitation approach. Can J Psychiatry. 2011; 56(12):751-760.

Government Agency, Medical Society, and Other Authoritative Publications:

1. Boston University Center of Psychiatric Rehabilitation. A Primer on the Psychiatric Rehabilitation Process. Available at: http://www.psychodyssey.net/wp-content/uploads/2011/10/Primer-on-the-Psych-Rehab-Process.pdf. Accessed on January 26, 2018.
2. Virginia Department of Medical Assistance Services. Psychosocial Rehabilitation. 2013. Available at: http://www.dmas.virginia.gov/Content_atchs/obh/cmh-trngs8.pptx. Accessed on January 26, 2018.
3. World Health Organization. International Classification of Functioning, Disability, and Health. Available at: http://www.who.int/classifications/icf/en/. Accessed on January 26, 2018.

Websites for Additional Information

1. National Association of Mental Illness (NAMI). Psychosocial Treatments. Available at: https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments. Accessed on January 26, 2018.
2. Substance Abuse and Mental Health Services Administration (SAMHSA). National Registry of Evidence-based Programs and Practices. Behind the term: serious mental illness. 2016. Available at: http://www.nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf. Accessed on January 26, 2018.

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History

Status	Date	Action
Reviewed	03/22/2018	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	02/23/2018	Behavioral Health Subcommittee review. The document header wording updated from "Current Effective Date" to "Publish Date". Updated References section.
Revised	08/03/2017	MPTAC review.
Revised	07/21/2017	Behavioral Health Subcommittee review. Formatting updated and acronyms removed and spelled out in Clinical Indications section. Definitions and References sections updated. Websites for Additional Information and Index sections added.
Reviewed	08/04/2016	MPTAC review.
Reviewed	07/29/2016	Behavioral Health Subcommittee review. Discussion and References sections updated. Removed ICD-9 codes from Coding section.
Revised	08/06/2015	MPTAC review.
Revised	07/31/2015	Behavioral Health Subcommittee review. Multiple clarifications to Medical Necessity Criteria. Moved Intensity of Service criteria to Discussion/General Information section. Description, Discussion/General Information and References sections updated.
New	08/14/2014	MPTAC review.
New	08/08/2014	Behavioral Health Subcommittee review. Initial document development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.