# Clinical UM Guideline

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| **Subject:** | Psychiatric Disorder Treatment | | |
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## Description

This document provides medical necessity criteria for levels of care relating to psychiatric disorder treatment (including treatment provided by a clinician licensed at the independent practice level) and medication management. This document does not address Applied Behavior Analysis (ABA) or ABA therapy.

The medical necessity criteria outlined in this document for each level of care relating to psychiatric disorder treatment 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.

Member's symptoms or condition should meet the diagnostic criteria for a Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis that is consistent with symptoms and the primary focus of treatment.

**Note:** Please see the following related documents for additional information:

- CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder
- CG-BEH-04 Substance-Related and Addictive Disorder Treatment
- CG-BEH-05 Eating and Feeding Disorder Treatment
- CG-MED-19 Custodial Care

## Clinical Indications

### Acute Inpatient

**Medically Necessary:**

*Severity of Illness Criteria*
Acute inpatient treatment is considered **medically necessary** when the member has A, B, C, or D and also has E:

A. **Imminent suicidal risk or danger to others –** immediate danger to self and/or others is apparent or behavior indicating a plan that would result in risk to self or others, such that the degree of intent, method, and immediacy of the plan requires a restrictive inpatient setting with psychiatric medical management and nursing interventions on a 24-hour basis; **or**
B. **Presence of acute psychotic symptoms –** severe clinical manifestations, symptoms or complications that creates immediate risk to self or others due to impairment in judgment which preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and requires 24- hour nursing/medical assessment, intervention and/or monitoring; **or**
C. **Grave disability –** acute impairment exists, as evidenced by severe and rapid decrease in level of functioning in several areas of life (work, family, activities of daily living [ADL's], interpersonal), to the degree that the member is unable to care for him or herself, and therefore is an imminent danger

to self or others which precludes diagnostic assessment and appropriate treatment in a less intensive treatment setting and requires 24-hour nursing/medical assessment, intervention and/or monitoring; **or**

D. **Self-injury or uncontrolled risk taking behaviors** or uncontrollable destructive behavior creating immediate risk to self or others which requires medical intervention and containment in a 24-hour a day acute setting; **and**
E. Member's clinical condition is of such severity that daily member medical evaluation by a physician or other provider with prescriptive authority is indicated.

*Continued Stay Criteria*
Acute inpatient treatment is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and one of B, C, or D:

A. Member evaluation by a physician or other provider with prescriptive authority occurred on each day; **and**
B. Progress with the psychiatric symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; **or**
C. If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable; **or**
D. There is no access to residential care or partial hospital care if this is needed.

**Not Medically Necessary:**

Acute inpatient treatment is considered **not medically necessary** when the above criteria are not met.

**Residential Treatment Center**

**Medically Necessary:**

*Severity of Illness Criteria*
Residential treatment center is considered **medically necessary** when the member has **all** of the following:

A. The member is manifesting symptoms and behaviors which represent a deterioration from the member's usual status and include either self injurious or risk taking behaviors that risk serious harm and cannot be managed outside of a 24 hour structured setting or other appropriate outpatient setting; **and**
B. The social environment is characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while the member is in the residential facility; **and**
C. There should be a reasonable expectation that the illness, condition or level of functioning will be stabilized and improved and that a short term, subacute residential treatment service will have a likely benefit on the behaviors/symptoms that required this level of care, and that the member will be able to return to outpatient treatment; **and**
D. Member's clinical condition is of such severity that an evaluation by physician or other provider with prescriptive authority is indicated at admission and weekly thereafter.

*Continued Stay Criteria*
Residential treatment center is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and one of B, C, or D:

A. Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**
B. Progress with the psychiatric symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; **or**
C. If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable; **or**
D. There is no access to partial hospital care if this is needed.

**Not Medically Necessary:**

Residential treatment center is considered **not medically necessary** when the above criteria are not met.

**Partial Hospitalization Program**

**Medically Necessary:**

*Severity of Illness Criteria*
Partial hospitalization program is considered **medically necessary** when the member has **all** of the following:

A. Behavioral Health Condition, with mental health signs and symptoms: The member exhibits serious or disabling symptoms related to an acute mental health condition, or exacerbation of a severe and persistent mental disorder, or severe and persistent symptoms and impairments that have not improved or cannot be adequately addressed in a less intensive level of care; **and**
B. Level of Functioning: Marked impairments in multiple areas of his/her daily life are evident. This may include marked impairments that preclude adequate functioning in areas such as self-care, or other more specific role expectations such as bill paying, working, cleaning, problem solving, decision-making, contacting supports, taking care of others, addressing safety issues, medication compliance, or managing time in a meaningful way; **and**
C. Risk/Dangerousness: The member is not imminently dangerous to self or others and is able to exercise adequate control over his/her behavior to function outside of 24 hour custodial care. However, the member may exhibit some identifiable risk for harm to self or others yet is able to develop and practice a safety plan with the structured intensive support of PHP treatment; **and**
D. Social Support System: The member is or can be connected with a community-based network, which supports the member within the home environment. The member may present with impaired ability to access or use caretaker, family or community support. In some cases a socially isolated person with serious debilitation symptoms may benefit. In other cases, a member from a troubled family may benefit as well. Minimal ability to set goals to work toward the development of social support is often a requirement for participation. In some cases, removal from a given residence or placement in a residential treatment setting may be a precondition for treatment; **and**
E. Readiness for Change: The presence of significant denial or pre-contemplation regarding change may often be anticipated due to the acute circumstances surrounding an admission. The member must however have the capacity for minimum engagement in the identification of goals for treatment, and willingness to try to participate actively in relevant components of the program. Initially, due to mental health and substance use disorder symptoms, the member may only be able to agree to begin treatment, and may require close monitoring, support and encouragement to achieve and sustain active and ongoing participation; **and**
F. Level of Care Rationale:
    1. The member has relapsed or failed to make significant clinical gains in a less intensive level of care; **or**
    2. Less intensive levels of care are judged insufficient to provide the treatment necessary; **or**

3. The member is ready for discharge from an inpatient setting, but is judged to be in continued need of ongoing intensive therapeutic interventions, daily monitoring, and support that cannot be provided in a less intensive level of care;
**and**

G. Member's clinical condition is of such severity that an evaluation by a physician or other provider with prescriptive authority is indicated at admission and weekly thereafter.

*Continued Stay Criteria*
Partial Hospitalization program is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

A. Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**
B. Progress with the psychiatric symptoms and behaviors is documented and the member is cooperative with treatment and is meeting treatment plan goals; **or**
C. If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

**Not Medically Necessary:**

Partial hospitalization program is considered **not medically necessary** when the above criteria are not met.

**Intensive Structured Outpatient Program**

Note: The state of New York allows Intensive Outpatient Program as defined by these criteria to be equivalent to Continuing Day Treatment (CDT) provided to New York Medicaid members.

**Medically Necessary:**

*Severity of Illness Criteria*
Intensive structured outpatient program is considered **medically necessary** when the member has **all** of the following:

A. The presence of moderate symptoms of a serious psychiatric diagnosis; **and**
B. Significant impairment in one or more spheres of personal functioning; **and**
C. The clear potential to regress further without specific IOP services; **and**
D. The need for direct monitoring less than daily but more than weekly; **and**
E. Specific Deficits that are directly related to services rendered; **and**
F. Significant variability in day to day capacity to cope with life situations; **and**
G. Member's clinical condition is of such severity that a psychiatric evaluation by a physician or other provider with prescriptive authority is indicated at admission.

*Continued Stay Criteria*
Intensive structured outpatient program is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

A. Member evaluation by a physician or other provider with prescriptive authority occurs in response to treatment issues such as medication effectiveness, side effects and other medical problems; **and**
B. Progress with the psychiatric symptoms and behaviors is documented and the member is cooperative with treatment and meeting treatment plan goals; **or**

C. If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

**Not Medically Necessary:**

Intensive structured outpatient program is considered **not medically necessary** when the above criteria are not met.

**Inpatient/Outpatient Electroconvulsive Therapy**

**Medically Necessary:**

*Severity of Illness Criteria*
Inpatient/outpatient electroconvulsive therapy is considered **medically necessary** when the member has A **and** either B **or** C:

A. Should have **one** of the following:
    1. History of a poor response to several trials of antidepressants in adequate doses for a sufficient time; **or**
    2. History of a good response to electroconvulsive therapy during an earlier episode of illness; **or**
    3. Need for a rapid response due to the severity of psychiatric or medical condition; **or**
    4. Adverse effects with medication which are deemed to be less likely and/or severe with electroconvulsive therapy; **and**
B. For outpatient electroconvulsive therapy, member must have adequate social and environmental support to maintain effective and safe treatment on an outpatient basis; **or**
C. For inpatient electroconvulsive therapy, member must meet Severity of Illness Criteria for psychiatric adult/adolescent/child inpatient.

*Continued Stay Criteria*
Inpatient/outpatient electroconvulsive therapy is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has the following:

A. Progress after the expected minimum number of treatments usually needed (based on the diagnosis) is being documented and maximal benefit has not yet been achieved.

**Not Medically Necessary:**

Inpatient/outpatient electroconvulsive therapy is considered **not medically necessary** when the above criteria are not met.

**Outpatient Treatment**

**Medically Necessary:**

*Severity of Illness Criteria*
Outpatient treatment is considered **medically necessary** when the member has **all** of the following:

A. Specific symptoms or disturbances of mood and/or behavior are present, with functional impairment, which are consistent with the DSM/ICD diagnosis listed, and these disturbances/symptoms are likely to improve with treatment; **and**
B. The member demonstrates motivation for treatment and is capable of benefiting from the treatment approach planned.

*Continued Stay Criteria*
Outpatient treatment is considered **medically necessary** when the member has the following:
*Frequency Criteria: for treatment that occurs more frequently than once per week (excluding Medication Management) should have **all** of the following:*

A. Either the member has been discharged from an inpatient, residential or partial hospitalization program service and more frequent outpatient treatment is required as a transition for the purposes of stabilization while returning to the community or the member is in crisis as evidenced by suicidal ideation or high risk behavior that is manageable on an outpatient basis, or an unexpected increase in symptoms and/or behaviors or worsening in mood where the treatment goals are focused on stabilization of the crisis; **and**
B. The symptoms/behaviors or mood that represent the crisis can be stabilized with more frequent treatment as evidenced by urgent psychiatric contact and medication changes if indicated and reports of progress with resolving the crisis; **and**
C. The condition has not stabilized to the point where less frequent treatment which targets less critical symptoms/behaviors is equally appropriate.

*Frequency Criteria: for treatment up to once per week (excluding Medication Management) should have **all** of the following:*

D. Progress with the targeted symptoms/behaviors and/or mood 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 symptoms and functional impairment and continued progress is expected for the targeted symptoms and behaviors or mood with the treatment approaches being used; **and**
E. 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 the treatment approach has been re-evaluated and changed if appropriate to include a diagnosis specific therapy, family therapy or new treatment goals/targets; **and**
F. The goals of treatment are not primarily for providing support and targets are not primarily symptoms/behaviors which are either chronic and not likely to improve with the type of treatment being used, or primarily self-improvement; **and**
G. Symptoms and/or functional impairment of at least a moderate degree as evidenced by report of specific domains are still present related to the DSM/ICD diagnoses listed and likely to improve with continued treatment; **and**
H. The member is allowing coordination of care with other providers and evidence of this is documented, and is involving family members where indicated; for children/adolescents, the family is participating in treatment and adhering to recommendations; **and**
I. The condition has not stabilized to the point where maintenance treatment is appropriate or where sustained improvement is not likely and the purpose of continued treatment is to prevent relapse or maintain previous achieved progress.

*Frequency Criteria: for treatment every other week, (excluding Medication Management) should have **all** of the following:*

J. Symptoms/behaviors or mood disturbances persist consistent with the DSM/ICD diagnoses listed which have not remitted as shown by moderate to severe symptoms and functional impairment, that require maintenance treatment to ensure that previously achieved progress in treatment is sustained and where relapse or deterioration is likely without this degree of continued treatment; **and**
K. Maintenance treatment cannot be provided by medication management alone or medication treatment is only partially effective and intermittent therapy support is required in addition to medication maintenance treatment. When treatment frequency is being transitioned from once weekly (or more) to once monthly (or less), a reduction in frequency to maintenance treatment should be done with a brief period of transition to maintain stability.

*Frequency Criteria: for treatment once monthly, (excluding Medication Management) should have **all** of the following:*

L. Symptoms/behaviors or mood disturbances persist consistent with the DSM/ICD diagnoses listed that require maintenance treatment to ensure that previously achieved progress in treatment is sustained and where relapse or deterioration is likely without this degree of continued treatment; **and**
M. Maintenance treatment cannot be provided by medication management alone or medication treatment is only partially effective and intermittent therapy support is required in addition to medication maintenance treatment.

**Not Medically Necessary:**

Outpatient treatment is considered **not medically necessary** when the above criteria are not met.

**Medication Management**

**Medically Necessary:**

*Severity of Illness*
Medication management is considered **medically necessary** when the member has **all** of the following:

A. Medical evaluation to determine whether there is a need for medication; **and**
B. Medical prescription of psychotropic drugs and on-going medication monitoring; **and**
C. Diagnoses from DSM or Psychiatric Diagnosis for ICD.

*Continued Stay Criteria*
Medication management is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has the following:

A. Progress is documented and the member is cooperative and motivated such that continued progress is expected, and if not then the treatment plan is being changed or if no further progress expected, then a maintenance plan is in effect.

**Not Medically Necessary:**

Medication management is 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 psychiatric disorder treatments. HCPCS codes for residential treatment and partial hospitalization may be utilized by Medicaid plans but may not be covered or valid for Medicare or other plans. Providers who have questions should contact the health plan for the billing/coding of facility based services, using codes such as revenue codes, for reimbursement.

***Residential Treatment Center***

| **HCPCS** | |
|---|---|
| H0017 | Behavioral health; residential (hospital residential treatment program), without room and board, per diem |
| H0018 | Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem |
| H0019 | Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem |

| **ICD-10 Diagnosis** | |
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| | *For the following diagnoses, including but not limited to:* |
| F01.50-F99 | Mental, behavioral and neurodevelopmental disorders |

***Partial Hospitalization Program***

| **HCPCS** | |
|---|---|
| H0035 | Mental health partial hospitalization, treatment, less than 24 hours |
| S0201 | Partial hospitalization services, less than 24 hours, per diem |

| **ICD-10 Diagnosis** | |
|---|---|
| | *For the following diagnoses, including but not limited to:* |
| F01.50-F99 | Mental, behavioral and neurodevelopmental disorders |

***Electroconvulsive Therapy (ECT)***

| **CPT** | |
|---|---|
| 90870 | Electroconvulsive therapy (includes necessary monitoring) |

| **ICD-10 Diagnosis** | |
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| | *For the following diagnoses, including but not limited to:* |
| F01.50-F99 | Mental, behavioral and neurodevelopmental disorders |

***Psychiatric Outpatient Treatment***

| **CPT** | |
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| | *For the following procedures when performed in the outpatient setting:* |
| 90832 | Psychotherapy, 30 minutes with patient |

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| 90833 | Psychotherapy, 30 minutes with patient when performed with an evaluation and management service [add-on] |
| 90834 | Psychotherapy, 45 minutes with patient |
| 90836 | Psychotherapy, 45 minutes with patient when performed with an evaluation and management service [add-on] |
| 90837 | Psychotherapy, 60 minutes with patient |
| 90838 | Psychotherapy, 60 minutes with patient when performed with an evaluation and management service [add-on] |

**ICD-10 Diagnosis**

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

***Medication Management***

**CPT**

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|---|---|
| 90863 | Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services [add-on] |

**ICD-10 Diagnosis**

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

## Discussion/General Information

Psychiatric disorders can include a wide range of mental health diagnoses. The illnesses are described in current diagnosis sources (DSM-5, ICD-9-CM). The type of service needed reflects the gravity and acuity of symptoms. Determining the appropriate level and place of treatment is important for potential safety of the member as well as addressing the concerns of family members and society. The criteria in this document capture problems that warrant differing levels of care, depending on the member's condition and circumstances. In addition, the document informs about the types of services to be provided in the different levels of care and changes in condition that suggest treatment with less intense services.

ABA and other types of behavioral interventions often used for autism spectrum disorders (ASD's) are based on learning principles. These treatments can be distinguished from outpatient therapy described above because treatment such as ABA incorporates elements of learning such as teaching the affected individual to read or work math problems. In addition, these treatments include elements characteristic of speech therapy such as naming objects. Finally, at least some individuals with ASD's need extensive coaching on tasks related to personal care such as toileting as part of the treatment. Treatment with ABA and related therapies can be complemented with outpatient therapy as described above with treatment such as family therapy addressing depression and irritability exhibited by parents, siblings and other family members of an individual suffering from ASD or medication visits to manage medications.

Psychiatric treatment should not be primarily for the avoidance of incarceration of the member or to satisfy a programmatic length of stay (refers to a pre-determined 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.

It is noted that there is variation in the availability of services in different geographic and regional areas. If an indicated service is not available within a member's community at the level of service indicated by the criteria, authorization may be given for those services at the next higher available level.

In some geographical areas, state regulations allow non-physicians to treat members at inpatient facilities. In these documents, such non-physicians with prescriptive authority who are operating within the scope of their license may be substituted where the criteria specifies a physician.

At each level of care, different facilities and programs offer and provide different services. However, common features should exist across all levels of care. For example, all levels of care should coordinate care with other clinicians, such as outpatient psychiatrist, therapist, and the member's primary care physician. In the instance of electroconvulsive therapy, the qualified physician performing the electroconvulsive therapy should confer regularly with the member's attending physician regarding the member's progress. For medication management, the physician or other prescriber collaborates with a psychotherapist (if there is one) and primary care physician as appropriate, when a prescription is initiated or changed. Coordination of care should occur at regular intervals and should be documented. Discharge planning should be in place across all levels of care including identification of the range of community/family resources.

The staff at each level of care should be able to provide care that is appropriate to the clinical needs of each member receiving treatment. The staff members should be properly licensed to provide the treatment requested. At the acute inpatient level, a physician directs and coordinates care and can visit at least daily, 7 days per week. In a residential treatment center, an evaluation should be done by a qualified physician within 48 hours, and physical exam and lab tests should be completed unless done prior to admission. Skilled nursing care (either by a registered nurse or licensed vocational nurse/licensed practical nurse) must be available on-site for at least 8 hours daily with 24 hour medical availability to manage medical problems if medical instability is identified as a reason for admission to this level of care. In a residential treatment center, there should be individual treatment with a qualified physician at least once a week including medication management if indicated and individual treatment with a licensed behavioral health clinician at least once a week. In a partial hospitalization program, programs operate under the direction of a physician and a program leader. The physician provides supervision of the clinical needs of the members enrolled in the program and the program leader is responsible for the overall clinical and administrative operations of the program. Physicians should have face to face contact on admission for an evaluation and thereafter as clinically indicated, at least one time a week. Coordination of care with the member's primary care provider must take place in any situation where there are medical comorbidities. A member of the clinical staff serves in a case management capacity to coordinate the member's treatment within the program and works consistently with the member (and family as indicated) and follows the course of clinical treatment from admission through discharge. Physicians need to be available for consultation with other staff and for face to face evaluations with members during program hours or by telephone outside of program hours, 24 hours a day, 7 days a week. Staff members must possess appropriate academic degrees, licensure, or certification as well as experience with the particular populations treated as defined by program function and applicable state regulations. Core clinical staff members may include: psychiatrists, psychologists, social workers, counselors, addiction counselors, medical and nursing personnel. Occupational, recreational and creative arts therapists may also provide services. Paraprofessionals, non-degreed individuals, students and interns may be included. In an intensive outpatient program, a psychiatric evaluation by a physician should be done by the third day of attendance (unless stepping down from a higher level of care) and thereafter as needed. For medication management, a qualified physician, psychiatric nurse practitioner (or physician extender or independently licensed clinician as permitted by law or health plan benefits) as appropriate prescribes the medication.

There are also distinct differences between facilities and programs in other types of services provided. At the acute inpatient level, a multi-disciplinary assessment with a treatment plan which addresses psychological, social, medical, and substance abuse needs should be in place. There should be documentation of blood and/or urine drug screen results upon admission and as appropriate. There should be a medication evaluation and documentation of rationale if no medication is being prescribed. When appropriate, there should be a family

assessment. For children and adolescents, therapy should be a minimum of 1 to 2 times per week with an initial family session expected to occur within the first 72 hours of admission, unless clinically contraindicated and suicide/homicide precautions should be in place as required.

Residential treatment takes place in a structured facility-based setting. Wilderness programs are not considered residential treatment. There should be documentation that shows a blood or urine drug screen was done on admission and during treatment if indicated. Within 72 hours, a multidisciplinary assessment should be done with an individualized problem-focused treatment plan completed, addressing psychiatric, academic, social, medical, family and substance use needs. Treatment would include the following at least once a day with each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy. Unless contraindicated, family members can participate in the development of the treatment plan, participate in family program and groups and receive family therapy at least once a week, including in-person family therapy at least once a month if the provider is not geographically accessible. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated. The treatment should be individualized and not determined by a programmatic timeframe. It is expected that members will be prepared to receive the majority of their treatment in a community setting. There should be a medication evaluation and documented rationale if no medication is being prescribed.

For a partial hospitalization program, multidisciplinary treatment should be provided at least 6 hours a day. The frequency of attendance per week may vary according to clinical needs and progress, but should probably start with 4 to 5 times a week. All services should consist of active treatment that specifically addresses the presenting problems of the members served and realistic goals that can be accomplished within the duration of treatment. Examples of active treatment include: group psychotherapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, and individual and family therapy. Involvement of the family, significant others and/or peers (as available and with signed consent) should be addressed in the mission and reflected in the program services offered. A clinical record is to be maintained for each member admitted. This should include the following elements: initial assessment, physician orders and certification of need for this level of care, psychiatric assessment, treatment plan addressing only the needs which are of such severity that the intensity of partial hospitalization program is needed with clear goals which are achievable within the timeframe of the program, medication management, progress notes and a discharge summary.

In an intensive outpatient program, treatment services should be offered at least 3 treatment hours per day at least 3 times per week. With symptom improvement, a gradual decrease in services per week may occur to help plan for successful discharge and greater independent functioning. In some cases an evidence-based, time limited treatment protocol is provided for a given condition which may include a given number of sessions over several weeks. A comprehensive clinical assessment should be done on admission that includes cognition/mental status, emotional/psychological function, activities of daily living, historical data (including social, medical and occupational histories), cultural issues, spirituality and medical screening. The treatment plan should be updated and individualized following previous treatment either from a higher or lower level of care. All services should consist of active treatment that specifically addresses the presenting problems of the members served and realistic goals that can be accomplished within the duration of treatment. Examples of active treatment include: group psychotherapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, and individual and family therapy. For children and adolescents, family therapy should be provided at least 1 time each week, unless clinically contraindicated. Group therapy should be individualized to meet the member's needs, based on specific clinical needs or functional level. A clinical record should be maintained for each member admitted. This should include the following elements: initial assessment, physician orders and certification of need for this level of care, psychiatric assessment, treatment plan addressing only the needs which are of such severity that the intensity of an intensive outpatient program is needed with clear goals which are achievable within the timeframe of the program, medication management, progress notes and a discharge summary.

For electroconvulsive therapy (ECT), a history and physical should have been completed within the 30 days prior to treatment and updated as needed. The qualified physician performing the electroconvulsive therapy procedure should write a procedure note for each electroconvulsive therapy treatment. The number and frequency of treatments requested should be appropriate to the member's clinical condition and response. In 2015, the United States Food and Drug Administration (FDA) issued guidance which provides recommendations for 510(k) submissions and re-classification of ECT devices from class III devices to class II devices. The recommendations also include indications for ECT for severe major depressive episode associated with major depressive disorder or bipolar disorder in individuals 18 years of age or older who are resistant to treatment or who require a rapid response due to the severity of their medical or psychiatric condition. The FDA also includes warnings in which use of an ECT device may be associated with disorientation, confusion, and memory problems.

For outpatient treatment, the treatment goals should target resolution of specific symptoms or stabilization of mood and/or behavior consistent with the DSM/ICD diagnoses listed and also target specific domains of functional impairment. Medication should be used for conditions where indicated, and if not, documentation of the reason and treatment interventions addressing the omission of this treatment. Physician medication management should be documented separately from psychotherapy. If a substance use disorder is known to be present or thought to be present, a substance use evaluation should have been performed and treatment provided as accepted by the member. Community/natural supports and resources should be identified and utilized or skills to develop community/natural supports is a treatment goal, including school/work interventions, self-help or diagnosis specific support groups, spiritual/religious, and community recreational activities. For children/adolescents, family participation in treatment or family therapy should be documented unless contraindicated with documentation of the reason. Treatment should not be duplicative of services being provided by another clinician for the same reasons/diagnoses.

Medication management services are provided face to face on a scheduled basis. The diagnostic evaluation should include substance use disorder screening. For acute illness, the member may be seen up to once or twice a week if not stabilized on medication or suffering from adverse side effects. Members who have stabilized or those with chronic symptoms may be seen monthly or less often, depending at least in part on medication tolerability. There should be adherence to documentation and treatment plan guidelines. Family involvement should be a part of child/adolescent management unless clinically contraindicated.

## Definitions

Acute Inpatient: Treatment in a hospital unit that includes 24-hour nursing and daily active treatment under the direction of a physician.

Residential Treatment Center: Twenty-four (24) hours per day specialized treatment involving at least one physician visit per week in a facility-based setting.

Partial Hospitalization Program: Structured, short-term outpatient treatment modality that offers nursing care and active treatment in a program that operates 6 hours per day, 5 days per week. Around-the-clock care would not be necessary.

Intensive Outpatient Program: Structured treatment that includes a combination of individual, group and family therapy in a treatment plan for members living in the community with problems responsive to a facility-based program of care delivered a few hours a day. Programs of this type have been identified by the state of New York as Intensive Psychiatric Rehabilitation Treatment (IPRT), Continuing Day Treatment (CDT) and by the state of Connecticut as Extended Day Treatment.

Outpatient Treatment: A behavioral health profession licensed to practice independently provides care to individuals in an outpatient, often an office, setting. Around-the-clock care would not be necessary.

## References

**Peer Reviewed Publications:**


1. Frances A, Kahn DA, Carpenter D, et al. The expert consensus guidelines for treating depression in bipolar disorder. J Clin Psychiatry. 1998. 59 (Suppl 4):73-79.
2. McEvoy JP, Scheifler PL, Frances A. Treatment of schizophrenia 1999. The expert consensus guideline series. J Clin Psychiatry. 1999; 60 Suppl 11:3-80.


**Government Agency, Medical Society, and Other Authoritative Publications:**


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## Index



## 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." |
| Revised | 08/03/2017 | MPTAC review. |
| Revised | 07/21/2017 | Behavioral Health Subcommittee review. Added note to Clinical Indications for IOP. |
| | 01/01/2017 | Updated Coding section with 01/01/2017 CPT descriptor revisions for codes 90832-90834, 90836-90838, |
| | 11/07/2016 | Updated Definition for Intensive Outpatient Program. |
| Revised | 08/04/2016 | MPTAC review. |
| Revised | 07/29/2016 | Behavioral Health Subcommittee review. Updated formatting in Clinical Indications section. Incorporation of service descriptions that take into consideration a member's medical needs. Updated Discussion/General Information, Definitions, and References sections. Updated Coding section and removed ICD-9 codes. |
| Revised | 08/06/2015 | MPTAC review. |
| Revised | 07/31/2015 | Behavioral Health Subcommittee review. Reformatted and clarified medically necessary criteria. Removed Intensity of Service criteria from medically necessary statements and moved to the Discussion section. Updated Description, Discussion/General Information, Definitions, and References. |
| Revised | 08/14/2014 | MPTAC review. |
| Revised | 08/08/2014 | Behavioral Health Subcommittee review. Multiple additions to Medical Necessity Criteria. Updated Description/Scope, Discussion/General Information, References and Index. Addition of Psychiatric outpatient treatment and Medication management criteria from CG-BEH-06 (Psychiatric Outpatient Treatment) added to the scope of this document. Removal of reference to global assessment of functioning scores from Medical Necessity Criteria. |
| Revised | 02/13/2014 | MPTAC review. |
| Revised | 02/07/2014 | Behavioral Health Subcommittee review. Removed indications of Axis from Clinical Indications. |
| New | 08/08/2013 | MPTAC review. |
| New | 07/26/2013 | Behavioral Health Subcommittee review. Initial document development. Clarification to Clinical Indications Partial Hospitalization Program and Intensity of Service. Updated References. The Behavioral Health Medical Necessity Criteria effective January 1, 2013 was split apart into specific subject matter clinical UM guidelines. |

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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.