Medical Necessity Criteria 2017

The New Directions Medical Necessity Criteria have been revised. The new version will be effective January 1, 2017. See https://www.ndbh.com/Providers/BehavioralHealthPlanProviders.aspx.

Significant changes are in the following:
- Definitions of Custodial Care and Domiciliary Care
- Hours of programming and time frames in Psychiatric and Substance Use Disorder Criteria sets
- Definition of all criteria sets for Substance Use Disorders
- Benefit denial language
- Additional criteria were added for Eating Disorder Inpatient and Residential Admission Criteria sets
- Within every criteria set, changes were made to the language in Admission Criteria and Continued Stay Criteria.

Notable Differences:
- In the Using the Medical Necessity Criteria section, the following definitions were added:
  - **Custodial Care**: This is care that does not require access to the full spectrum of services performed by licensed health care professionals that is available 24 hours a day in facility-based settings to avoid imminent, serious, medical or psychiatric consequences. In determining whether a person is receiving custodial care, we consider the level of care and medical supervision required and furnished, and whether the treatment is designed to improve or maintain the current level of function. We do not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

  By “facility-based,” we mean services provided in a hospital, long term care facility, extended care facility, skilled nursing facility, residential treatment center (RTC), school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long-term care can also be provided in the patient’s home, however defined.

  Custodial or long-term care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:

  1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing
2. Homemaking, such as preparing meals or special diets
3. Moving the patient
4. Acting as companion or sitter
5. Supervising medication that can usually be self-administered
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature and respiration; or administration and monitoring of feeding systems.

- **Domiciliary Care**: care provided because care in the patient’s home is not available or is unsuitable.

- In every Admission and Continued Stay Criteria set, along with 23-Hour Observation and ECT Admission Criteria, the following criteria were edited to state the following:
  - There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.

- In every Admission and Continued Stay Criteria set, the following criteria were edited to state the following:
  - The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.

- In every Psychiatric, Substance Use Disorder and Eating Disorder Continued Stay Criteria set at the inpatient or residential levels of care, the following statement was included:
  - There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner within seven days of discharge.

- In the Benefit Denial Criteria section for every criteria set including Inpatient ECT, the language was changed on Criteria 1 to state the following:
  - Despite intensive efforts, the member refuses to fully cooperate with the treatment plan and, as a result, there is no longer a reasonable expectation of reduction in symptoms/behaviors with the current treatment plan at this level of care.

- In the Substance Use Disorder Admission and Continued Stay Criteria sets for Inpatient Detoxification, Residential/Subacute Detoxification and Ambulatory Detoxification the language was changed to state the following:
  - A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active, daily detoxification treatment.
In every Substance Use Disorder Intensity of Service Criteria set, the following criteria was added:
  - The need for Medication-Assisted Treatment (MAT) unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.

The table below indicates the changes made to Intensity of Service, Admission and Continued Stay criteria in Psychiatric, Substance Use Disorder and Eating Disorder Criteria sets that are not listed above. The 2016 criteria are on the left, and the new 2017 criteria are on the right.

<table>
<thead>
<tr>
<th>2016 Psychiatric Acute Inpatient Criteria</th>
<th>2017 Psychiatric Acute Inpatient Criteria</th>
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</thead>
<tbody>
<tr>
<td><strong>Intensity of Service</strong></td>
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</tr>
<tr>
<td>Add: 7. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend, unless the facility network contract specifies different treatment time requirements.</td>
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<table>
<thead>
<tr>
<th>2016 Psychiatric Residential Criteria</th>
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<tr>
<td><strong>Intensity of Service</strong></td>
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</tr>
<tr>
<td>4. The attending physician is responsible for diagnostic evaluation within 48 hours of admission and the physician or physician extender provides face-to-face evaluation a minimum of weekly thereafter with documentation and is available 24 hours per day seven days per week.</td>
<td>4. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission and the physician or physician extender provides face-to-face evaluation a minimum of weekly thereafter with documentation and is available 24 hours per day seven days per week.</td>
</tr>
<tr>
<td><strong>Add:</strong> 9. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend,</td>
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<table>
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<tr>
<th>2016 Psychiatric Partial Hospitalization</th>
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<td>3. The attending physician is responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides a face-to-face evaluation with documentation as indicated, no less than weekly.</td>
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<td>4. After a multidisciplinary assessment, and within three (3) days of admission, an individualized treatment plan using evidenced-based concepts, where applicable, is developed and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.</td>
<td>4. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.</td>
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<tr>
<td>5. Treatment program includes a minimum of one member counseling session per week with a licensed</td>
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</table>
11. b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.

**2016 Psychiatric Intensive Outpatient**

<table>
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<td>5. Treatment program includes a minimum of one member counseling session per week with a licensed therapist.</td>
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**2017 Psychiatric Intensive Outpatient**

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11. b. For children/adolescents: Family treatment will be provided as part of the treatment plan unless clinically contraindicated. The family/support system assessment will be completed within five days of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur no less than weekly.

**Admission Criteria**

<table>
<thead>
<tr>
<th>2016 Psychiatric Outpatient</th>
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<tbody>
<tr>
<td>5. The member is cognitively capable to actively engage in the recommended treatment plan, and the member is expressing willingness to engage in recommended treatment plan.</td>
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<table>
<thead>
<tr>
<th>2017 Psychiatric Outpatient</th>
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<tr>
<td>5. The member is cognitively capable to actively engage in the recommended treatment plan.</td>
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<table>
<thead>
<tr>
<th>2016 Substance Use Disorder Inpatient Detoxification</th>
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<tbody>
<tr>
<td>5. After a multidisciplinary assessment, and within three (3) days of admission, an individualized treatment plan using evidence-based concepts, where applicable, is developed and amended as needed for changes in the individual’s clinical condition. This plan should reference the following to develop treatment and discharge plans focused on the member: a. Precipitants to admission b. Current function and symptoms c. Family/other support systems d. Community resources e. Medication Assisted Treatment unless medically as needed.</td>
</tr>
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<td>5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 24 hours of admission and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.</td>
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Admission Criteria

5. The member is cognitively capable to actively engage in the recommended treatment plan, and the member is expressing willingness to engage in recommended treatment plan.

6. The member is expressing willingness to engage in recommended treatment plan.
contraindicated, especially in members who have significant cravings or repeated relapses.

### Admission Criteria

2. The identified substance used is known to have a serious potential for morbidity or mortality during the withdrawal period OR is known to have a serious potential for medical comorbidity that in combination with substance dependence will lead to potentially life-threatening health risks (e.g., heart condition, pregnancy, history of seizures, major organ transplant, HIV, and diabetes, etc.)

4. Signs and symptoms of active severe withdrawal are present or expectation of such within the next 48 hours, or a historical pattern of withdrawal requiring a 24-hour medical and nursing intervention to prevent potentially life-threatening consequences. Withdrawal signs include, but are not limited to:
   - Temperature > 101 degrees
   - Pulse > 110 at rest
   - Hyperreflexia
   - Noticeable, paroxysmal diaphoresis at rest
   - Moderate to severe tremor at rest

5. History of seizures or delirium tremens (DTs)

Add:
- 2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
- 3. The identified substance used is known to have a serious potential for morbidity or mortality during the withdrawal period including alcohol, barbiturates, and benzodiazepines.

Add:
- 4. UDS or breathalyzer documentation of use
- 5. There are at least three signs and symptoms of active severe withdrawal that are present or expectation within the next 48 hours, or a historical pattern of withdrawal requiring a 24-hour medical and nursing intervention to prevent potentially life-threatening consequences. Withdrawal signs include, but are not limited to:
  - Temperature > 101 degrees
  - Pulse > 110 at rest and BP > 140/90
  - Hyperreflexia
  - Noticeable, paroxysmal diaphoresis at rest
  - Moderate to severe tremor at rest, as observed in outstretched arms

Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in bullet list above.

6. History of seizures or delirium tremens (DTs) during previous withdrawal episodes

Add:
- 8. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents potentially life-threatening health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.

### Continued Stay Criteria

**Must meet all of the following:**

1. A current DSM diagnosis of substance dependency is the primary focus of active, daily detoxification treatment.
2. Must have persistent, medically significant objective withdrawal signs including, but not limited to:
   - Temperature > 101 degrees
   - Pulse > 110 at rest Noticeable, paroxysmal

**Must meet 1 to 3 and at least one of 4, 5 or 6:**

1. A current DSM diagnosis of substance induced disorder with withdrawal is the primary focus of active, daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed

---

5
diaphoresis at rest
• Hyperreflexia
• Moderate to severe tremor at rest

3. The treatment is not primarily social, custodial, interpersonal or respite care.

Note: Detoxification treatment using “fixed tapers” without documentation of serious withdrawal symptoms from substance(s) known to potentially cause serious medical morbidity will not necessarily qualify for inpatient reimbursement.

4. Must have at least three persistent, medically significant objective withdrawal signs, including but not limited to:
   • Temperature > 101 degrees
   • Pulse > 110 at rest and BP > 140/90
   • Noticeable, paroxysmal diaphoresis at rest
   • Hyperreflexia
   • Moderate to severe tremor at rest, as observed in outstretched arms

   Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in bulleted list above.

5. Comorbid medical condition(s) that, in combination with substance dependence/detoxification, presents potentially life-threatening health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.

6. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.

   Note: Detoxification treatment using “fixed tapers” without documentation of serious withdrawal symptoms from substance(s) known to potentially cause serious medical morbidity will not necessarily qualify for inpatient reimbursement.

### 2016 Substance Use Disorder Residential/Subacute Detoxification

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>5. After a multidisciplinary assessment, and within three (3) days of admission, an individualized treatment plan using evidenced-based concepts, where applicable, is developed and amended as needed for changes in the individual’s clinical condition. This plan should reference the following to develop treatment and discharge plans focused on the member:</td>
</tr>
<tr>
<td>a. Precipitants to admission</td>
</tr>
<tr>
<td>b. Current function and symptoms</td>
</tr>
<tr>
<td>c. Family/other support systems</td>
</tr>
<tr>
<td>d. Community resources</td>
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<tr>
<td>e. Medication Assisted Treatment unless medically contraindicated, especially in members who have significant cravings or repeated relapses.</td>
</tr>
</tbody>
</table>

### Admission Criteria

**Must meet 1-3 and at least one of 4-7:**
1. A DSM diagnosis of substance dependency, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal or respite care.

### 2017 Substance Use Disorder Residential/Subacute Detoxification

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<tr>
<td>5. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 72 hours of admission and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.</td>
</tr>
</tbody>
</table>

### Admission Criteria

**Must meet 1-4 and at least one of 5, 6, 7, 8 or 9:**
1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. Specific documentation of current substances used must include:
   a. Substance used
   b. Duration of use
   c. Frequency of use
   d. Last date of use
   e. Quantity used per time period

4. Specific documentation of current substances used must include:
   a. Substance used
   b. Duration of use
   c. Frequency of use
   d. Last date of use
   e. Quantity used per time period

5. History of seizures or delirium tremens (DT's)
6. Comorbid medical condition(s) that in combination with substance dependence presents potentially life-threatening health risks (including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, and diabetes)
7. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.

### Continued Stay Criteria

**Must meet all of the following:**
1. A DSM diagnosis of substance abuse or dependency (substance use disorder), which is the primary focus of active daily detoxification treatment.
2. Must have persistent, medically significant objective withdrawal signs, including:
   a. Temperature > 101 degrees
   b. Pulse > 110 at rest
   c. Hyperreflexia
   d. Noticeable, paroxysmal diaphoresis at rest
   e. Moderate to severe tremor at rest

### Continue Stay Criteria

**Must meet 1 – 3 and at least one of 4, 5, 6, 7 or 8:**
1. A DSM diagnosis of substance induced disorder with withdrawal, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. There is documentation that the member has accepted a scheduled follow-up appointment with a licensed behavioral health practitioner with seven days of discharge

Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in the bulleted list above.

For Opioid withdrawal, must have at least three of the following symptoms:
1. Muscle aches, nausea, fever, GI cramps (which may progress to vomiting or diarrhea), dilated pupils, piloerection, runny nose, watery eyes, intense dysphoria or insomnia
2. History of seizures or delirium tremens (DT's)
3. Comorbid medical condition(s) that, in combination with substance dependence or detoxification, presents significant health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.
4. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.
3. The treatment is not primarily social, custodial, interpersonal or respite care.
4. Continuing, active symptoms of withdrawal remain that can only be safely managed in the current setting.

**Note:** Detoxification treatment using “fixed tapers” without documentation of serious withdrawal symptoms from substance(s) known to potentially cause serious medical morbidity will not necessarily qualify for residential/subacute reimbursement.

4. Must have at least three persistent, medically significant objective withdrawal signs, including:
   a. Temperature > 100 degrees
   b. Pulse > 100 at rest and BP > 140/90
   c. Hyperreflexia
   d. Noticeable, paroxysmal diaphoresis at rest
   e. Mild to moderate tremor at rest, as observed in outstretched arms

Note: Facilities may substitute a validated scale such as CIWA or COWS in lieu of listing symptoms in bulleted list above.

5. For Opioid withdrawal, must have at least three of the following symptoms:
   a. Muscle aches, nausea, fever, GI cramps (which may progress to vomiting or diarrhea), dilated pupils, piloerection, runny nose, watery eyes, intense dysphoria or insomnia

6. Comorbid medical condition(s) that in combination with substance dependence/detoxification presents significant health risks, including but not limited to heart condition, pregnancy, history of seizures, major organ transplant, HIV, diabetes, etc. Medical input suggested.

7. Psychiatric comorbidity that renders the member incapable of cooperating with or tolerating detoxification at a lower level of care.

**2016 Substance Use Disorder Ambulatory Detoxification**

**2017 Substance Use Disorder Ambulatory Detoxification**

### Intensity of Service

1. Services provided by licensed and appropriately trained personnel who can monitor withdrawal symptoms and implement physician approved protocols.

1. Services provided by licensed, certified and appropriately trained personnel who can monitor withdrawal symptoms and implement physician approved protocols.

### Admission Criteria

4. Specific documentation of current substances used to include:
   a. Substance used
   b. Duration of use
   c. Frequency of use
   d. Last date of use
   e. Quantity used per time period

3. Specific documentation of current substances used to include:
   a. Substance used
   b. Duration of use
   c. Frequency of use
   d. Last date of use
   e. Quantity used per time period
   f. UDS or breathalyzer documentation of use

### 2016 Substance Use Disorder Inpatient Rehabilitation

### 2017 Substance Use Disorder Inpatient Rehabilitation

### Intensity of Service

Add: 10. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>5. There are no psychiatric symptoms or cognitive deficits that would preclude the member from</td>
<td>5. The member is able to actively participate in his/her substance use disorder treatment.</td>
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<tr>
<td>participating in the program.</td>
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<tr>
<td>6. Member has marked medical morbidity from substance use disorder requiring active daily medical</td>
<td>6. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the inpatient level of care.</td>
</tr>
<tr>
<td>evaluation and management, not merely observation, and the member must be able to actively participate in</td>
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<tr>
<td>his/her substance use disorder treatment.</td>
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<tr>
<td>7. Member meets criteria 4, 5, 6, 7 or 8 for Psychiatric Acute Inpatient admission, AND the member must</td>
<td>7. Member has marked medical morbidity from substance use disorder requiring active daily medical</td>
</tr>
<tr>
<td>be able to participate in his/her substance use disorder treatment.</td>
<td>evaluation and management, not merely observation.</td>
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<thead>
<tr>
<th>Continued Stay Criteria</th>
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</tr>
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<tbody>
<tr>
<td>9. Member continues to meet criteria 4, 5, 6, 7 or 8 for Psychiatric Acute Inpatient admission.</td>
<td>10. There are acute psychiatric symptoms or cognitive deficits of severe intensity that require concurrent mental health treatment at the inpatient level of care.</td>
</tr>
</tbody>
</table>

| 2016 Substance Use Disorder Residential/Subacute Rehabilitation | 2017 Substance Use Disorder Residential/Subacute Rehabilitation |
| Intensity of Service                                                                 | Intensity of Service                                                                 |
| Add: 10. Multidisciplinary treatment program that occurs a minimum of six hours per day for a minimum of five days during the week, and four hours daily on the weekend |                                                                                      |

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<td>6. There are no psychiatric symptoms or cognitive deficits that would preclude the member from participating in the program.</td>
<td>Add: 4. The member is able to actively participate in his/her substance use disorder treatment.</td>
</tr>
<tr>
<td>7. Must have one or more of the following:</td>
<td></td>
</tr>
<tr>
<td>a. The member’s family members and/or support system demonstrate behaviors that are likely to undermine goals of treatment, such that treatment at a lower level of care is unlikely to be successful.</td>
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<tr>
<td>b. The member has documented recent history of an inability to be treated at an intensive lower level of care.</td>
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<tr>
<td>c. There is a recent (in the last six months) history of multiple episodes of 24-hour care without a successful transition to a lower level of care.</td>
<td></td>
</tr>
<tr>
<td>8. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs or the member has morbidity from substance use disorder requiring at least weekly medical evaluation and management.</td>
<td>7. There are acute psychiatric symptoms or cognitive deficits of moderate to severe intensity that require concurrent mental health treatment at the RTC level of care.</td>
</tr>
<tr>
<td>8. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs or the member has morbidity from substance use disorder requiring at least weekly medical evaluation and management.</td>
<td>8. The member’s environment and support system demonstrate moderate to severe lack of support and the member is unlikely to succeed in treatment at a lower level of care.</td>
</tr>
<tr>
<td>9. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical costs or the member has morbidity from substance use disorder requiring at least weekly medical evaluation and management.</td>
<td>9. In the last six months, there is a history of at least several episodes of 24-hour care without a</td>
</tr>
<tr>
<td>10. This level of care is necessary to provide structure for treatment of at least one of the following:</td>
<td></td>
</tr>
<tr>
<td>a. The member has a documented very high risk for relapse (lack of support, dangerous environment, lack of skills, etc).</td>
<td></td>
</tr>
<tr>
<td>b. The member has a documented recent history of an inability to be successfully treated at an intensive lower level of care.</td>
<td></td>
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<tr>
<td>c. In the last six months, there is a history of at least several episodes of 24-hour care without a</td>
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### Continued Stay Criteria

**2. There is a reasonable expectation of improvement in the acute behavior/symptom intensity with continued treatment at this level of care.**

### Continued Stay Criteria

**2. There is a reasonable expectation of reduction in behaviors/symptoms with the proposed treatment at this level of care.**

### 2016 Substance Use Disorder Partial Day Rehabilitation

#### Intensity of Service

3. After a multidisciplinary assessment, and within three (3) days of admission, an individualized treatment plan using evidence-based concepts, where applicable, is developed and amended as needed for changes in the individual’s clinical condition. This plan should reference the following to develop treatment and discharge plans focused on the member:

- a. Precipitants to admission
- b. Current function and symptoms
- c. Family/other support systems
- d. Community resources
- e. Medication Assisted Treatment unless medically contraindicated, especially in members who have significant cravings or repeated relapses.

### Admission Criteria

5. There are no psychiatric symptoms or cognitive deficits that would preclude the member from participating in the program.

6. The member’s environment and/or social supports do not support rehabilitation without daily structured interventions.

9. This level of care is necessary to provide structure for treatment of current symptoms:

   a. that cannot be managed at a lower level of care, or
   b. when current ongoing intensive outpatient care has failed to improve functioning, or
   c. when there is a clear risk for admission to a higher level of care

### 2017 Substance Use Disorder Partial Day Rehabilitation

#### Intensity of Service

3. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.

### Admission Criteria

Add: 4. The member is able to actively participate in his/her substance use disorder treatment.

6. There are acute psychiatric symptoms or cognitive deficits of moderate intensity that require concurrent mental health treatment at the PHP level of care.

7. The member’s environment and support system demonstrate mild to moderate lack of support, but the member can succeed in treatment with the intensity of current treatment services (30 hours/week).

10. This level of care is necessary to provide structure for treatment when at least one of the following exists:

   a. high likelihood of relapse without near daily treatment support
   b. current ongoing intensive outpatient care has failed to improve functioning, or
   c. clear risk for admission to a higher level of care

### Continued Stay Criteria

Add: 7. There are acute psychiatric symptoms or cognitive deficits of moderate intensity that require concurrent mental health treatment at the PHP level of care (Criteria 4 and 7).
### 2016 Substance Use Disorder Intensive Outpatient Rehabilitation

#### Admission Criteria

6. There are no psychiatric symptoms or cognitive deficits that would preclude the member from participating in the program.

7. The member's environment and/or social supports do not support rehabilitation without daily structured interventions.

9. This level of care is necessary to provide structure for treatment of at least one (1) of the current symptoms:
   - a. that cannot be managed at a lower level of care
   - b. when current ongoing outpatient care has failed to improve functioning
   - c. when there is a clear risk for admission to a higher level of care

### 2017 Substance Use Disorder Intensive Outpatient Rehabilitation

#### Admission Criteria

6. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care (Criteria 6 and 7). The member's environment and support systems are supportive of rehabilitation and the member can succeed in treatment with the intensity of current treatment services.

9. This level of care is necessary to provide structure for treatment when at least one of the following exists:
   - a. moderate likelihood of relapse without treatment structure multiple days/week
   - b. current ongoing outpatient care has failed to improve functioning
   - c. clear risk for admission to a higher level of care

### Continued Stay Criteria

Add: 6. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care (Criteria 6 and 7).

Add: 7. A member’s readiness for change and identified barriers to change are documented and addressed with appropriate therapeutic interventions.

Add: **Note:** Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography, etc.) is not the sole reason for continued stay in the program.

### 2016 Substance Use Disorder Outpatient Rehabilitation

#### Intensity of Service

2. After a multidisciplinary assessment, and within three (3) sessions of admission, an individualized treatment plan using evidenced-based concepts, where applicable, is developed and amended as needed for changes in the individual's clinical condition. This plan should reference the following to develop treatment and discharge plans focused on the member:
   - a. Precipitants to admission
   - b. Current function and symptoms
   - c. Family/other support systems
   - d. Community resources
   - e. Medication Assisted Treatment unless medically contraindicated, especially in members who have significant cravings or repeated relapses.

### 2017 Substance Use Disorder Outpatient Rehabilitation

#### Intensity of Service

2. An individualized treatment plan guides management of the member’s care. Treatment provided is timely, appropriate and evidence-based, including referral for both medical and/or psychiatric medication management as needed

### 2016 Eating Disorder Acute Inpatient

### 2017 Eating Disorder Acute Inpatient
Admission Criteria

5. Member has less than 75 percent of ideal body weight and/or BMI less/equal to 15.

6. There are active biomedical complications that require 24-hour care, including but not limited to:
   - Orthostatic changes in BP
     - Systolic: > 20 point drop
     - Diastolic: > 10 point drop
   - Body Temperature
     - < 97°F
   - Electrolytes/serum Chemistry
     - Significant deviation from normal

7. Must meet one of the following:
   - Compensatory behaviors (e.g., binging, purging, laxative abuse, excessive exercising, etc.) have caused significant physiologic complications that required urgent medical treatment.
   - Compensatory behaviors occur multiple times daily and have failed to respond to treatment at an intensive lower level of care and acute physiologic imbalance can be reasonably expected.

2016 Eating Disorder Residential

Admission Criteria

6. There are active biomedical complications that require 24-hour care, including but not limited to:
   - Orthostatic changes in BP

2017 Eating Disorder Residential

Admission Criteria

6. There are active biomedical complications that require 24-hour care, including but not limited to:
<table>
<thead>
<tr>
<th>(Supine to standing) systolic: &gt; 20 point drop</th>
<th>Adults</th>
<th>Children/Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>diastolic: &gt;10 point drop</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Body Temperature
<97 F
Abnormal core temperature

Electrolytes/serum Chemistry
Significant deviation from normal
Significant deviation from normal

<table>
<thead>
<tr>
<th>Orthostatic changes BP AND pulse</th>
<th>Supine to standing measured with 3-minute wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add: pulse: &gt; 20 bpm increase pulse: &gt; 20 bpm increase</td>
<td></td>
</tr>
<tr>
<td>Add: Sodium 125 meq/l 130 meq/l</td>
<td></td>
</tr>
<tr>
<td>Add: Magnesium/Phosphate Below normal range Below normal range</td>
<td></td>
</tr>
<tr>
<td>Body Temperature &lt;96 °F or cold blue extremities &lt;96 °F or cold blue extremities</td>
<td></td>
</tr>
</tbody>
</table>

7. b. Persistence or worsening of eating disorder behavior despite recent (with the last three months), appropriate therapeutic intervention in a structured eating disorder treatment setting. If PHP or IOP is contraindicated, documentation of the rationale supporting the contraindication is required. One of the following must be present:

### 2016 Eating Disorder Partial Hospitalization

<table>
<thead>
<tr>
<th>Intensity of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. The attending physician is responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides a face-to-face evaluation with documentation as indicated, but no less than weekly.</td>
</tr>
<tr>
<td>4. After a multidisciplinary assessment, and within three days of admission, an individualized treatment plan using evidenced-based concepts, where applicable, is developed and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.</td>
</tr>
<tr>
<td>5. Treatment program includes a minimum of one member counseling session per week with a licensed therapist.</td>
</tr>
</tbody>
</table>

### Admission Criteria

7. The member needs supervision during and/or after meals to ensure adequate nutritional intake and prevent compensatory behavior.

### 2017 Eating Disorder Partial Hospitalization

<table>
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<td>3. The attending physician is a psychiatrist and responsible for diagnostic evaluation within 48 hours of admission. Thereafter, the physician or physician extender provides a face-to-face evaluation with documentation as indicated, but no less than weekly.</td>
</tr>
<tr>
<td>4. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual’s clinical condition. This plan should reference precipitants to admission, current function and symptoms, family/other support systems and community resources to develop treatment and discharge plans focused on the member.</td>
</tr>
<tr>
<td>5. Treatment program includes a minimum of one member individual counseling session per week with a licensed therapist.</td>
</tr>
</tbody>
</table>

### Admission Criteria

7. The member needs daily supervision during and/or after most meals to ensure adequate nutritional intake and prevent compensatory behavior.

### 2016 Eating Disorder Intensive Outpatient

<table>
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<tr>
<td>3. There is documentation of evaluation by a physician within one week of admission and available as</td>
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### Admission Criteria

7. The member needs daily supervision during and/or after most meals to ensure adequate nutritional intake and prevent compensatory behavior.

### 2017 Eating Disorder Intensive Outpatient

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indicated thereafter.  
5. Treatment program includes a minimum of one member counseling session per week with a licensed therapist  

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<tr>
<td>3. Individualized treatment plan that guides management of the member’s care. Treatment provided is timely, appropriate, and evidence-based, including referral for and prescription of medications as needed.</td>
<td>3. Individualized treatment plan that guides management of the member’s care. Treatment provided is timely, appropriate, and evidence-based, including referral for both medical and/or psychiatric medication management as needed.</td>
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