

Medical Necessity and Level of Care Determination Criteria

The current version of this document is the online version. It can be found at priorityhealth.com/provider/manual/auths/bh/mednecessity/.

Note: In December 2009, Priority Health adopted the “Patient Practice Guidelines” from the American Society of Addiction Medicine (ASAM PPC-2R) to guide authorization decision making for patients with substance use disorders. The ASAM PPC-2R is the most widely used and comprehensive national guideline for placement continued stay and discharge of patients with alcohol or other drug problems

Priority Health applies clinical criteria using the philosophy that the most appropriate level of care for patients should be the safest *and* least restrictive possible. The goal of treatment is to restore the patient to an optimal level of functioning and independence. Application of these criteria takes into consideration the fact that individual patients vary in their level of clinical complication, and that the full continuum of clinical services does not exist in all geographic areas. Under circumstances of patient complexity or limited service availability, we will recommend a higher level of care than medically necessary in order to ensure safe, effective treatment. The term “Medical Necessity” is used to mean care that is determined to be effective, appropriate and necessary to treat a given patient’s disorder.

Each level of care is indicated as either for psychiatric or substance use disorders (except for the outpatient level of care, which includes both), and review for level of care determination proceeds in a logical progression to confirm:

- The presence of a properly diagnosed psychiatric or substance use disorder amenable to treatment,
- Symptoms of sufficient severity to meet the required criteria for admission,
- The illness by accepted medical standards is expected to improve significantly through medically necessary and appropriate care as it relates to the level of care requested, and
- Clinical requirements for continuing care at that level.

Discharge criteria, program content, treatment interventions, etc., are not included in an attempt to avoid being too prescriptive and preempting clinical discourse. Therefore, determinations for discharge from a given level of care are clear: when the patient no longer appears to meet the required criteria for continuing care at a given level of acuity, discharge to a lower level of care is recommended.

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Priority Health clinical criteria are reviewed annually by the Behavioral Health Committee. The committee is composed of a multidisciplinary group of mental health and substance use disorder treatment providers and includes fully licensed physicians, psychologists, social workers and board-certified psychiatrists. Priority Health medical director(s) and the department director are voting members of this group.

Members come first

Priority Health makes every effort to make utilization decisions that are fair and consistent in order to serve the best interests of the member. That is why Priority Health:

- Will make utilization decisions based only on appropriateness of care and service, as well as existence of coverage;
- Will not compensate practitioners or other individuals conducting utilization review for denial of coverage or service;
- Will not offer financial incentives for utilization decision-makers to encourage denial of coverage or service;
- Will decide on coverage of new technology after comprehensive research and careful review by our medical directors and physician committees.

Definitions for Levels of Care: Psychiatric Disorders

Priority Health recognizes the following as distinct levels of care:

- ▶ **Acute Inpatient** — The highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.
- ▶ **Residential Treatment** — Care provided at a sub-acute level with skilled nursing care. These services can be provided in intermediate care facilities (ICFs) or have other licensing designations that may vary by state.
- ▶ **Crisis Residential Treatment** — Crisis Residential is a non-medical, supervised, structured living arrangement for patients in a partial hospital program. The residential program is used for short-term, crisis stabilization and provides supervised overnight care in a non-medical setting.
- ▶ **Partial Hospital** — An intensive non-residential level of service where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to an inpatient setting, meeting for more than four hours (and, generally, less than eight hours) daily.
- ▶ **Intensive Outpatient** — Multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These are generally up to four hours per day, up to five days per week. Common treatment modalities include individual, family and group psychotherapy and medication management.
- ▶ **Outpatient** — The least intensive level of service, provided in an office setting. Individual psychotherapy sessions occur for up to 60 minutes per day and group psychotherapy sessions for up to 90 minutes per day.
- ▶ **23-Hour Observation** — “23-hour beds” are defined as a period of up to 23 hours during which services are provided at less than an acute level of care. It is indicated for those situations where acute inpatient criteria are not met because of external factors relative to information gathering or risk assessment, yet the patient is clearly at risk for harm to self or others.

23-Hour Observation (all age groups)

Note: “23-hour beds” are defined as a period of up to 23 hours during which services are provided at less than an acute level of care. It is indicated for those situations where full criteria are not met because of external factors relative to information gathering or risk assessment, yet the patient is clearly at risk for harm to self or others.

A. Medical Necessity — *All* must be met to consider for treatment

1. The patient must have been assessed, to a reasonable degree of medical certainty, as having a psychiatric illness or substance use disorder by a licensed health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and the patient.

B. Admission Criteria (*Either* 1 or 2 are sufficient to recommend treatment)

1. The presenting clinical problem likely represents a transient disruption of the patient’s clinical baseline, which will likely remit, with a period of structure and observation.

and

2. The presenting clinical problem represents a clear, proximal risk of harm to self or others.

Inpatient (Acute Care) Psychiatric: Adults, Geriatric (adults over the age of 65), Adolescent and Child

A. Medical Necessity (Criteria 1, 2 *and either* 3, 4 *or* 5 must be met to satisfy the criteria for admission)

1. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness must be documented through the assignment of appropriate DSM-IV codes on all applicable axes (I-V).
2. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment, including, but not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
3. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
 - A current plan or intent to harm self with an available and lethal means, or
 - Recent severe self-harm behavior or suicide attempt, with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for their safety, or
 - Imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, or
 - Other similarly clear and reasonable evidence of imminent serious harm to self.
4. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

- A current plan or intent to harm others with an available and lethal means, or
 - A recent, severe attempt to harm others, with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for their safety, or
 - Violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, or
 - Other similarly clear and reasonable evidence of imminent serious harm to others.
5. The patient's condition requires an acute psychiatric assessment technique or intervention that, unless managed in an inpatient setting, would have a high probability of leading to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

B. Admission Criteria (*All* are required to consider for admission)

1. The patient must be medically evaluated and cleared of co-morbid medical conditions that may be contributing to the psychiatric condition prior to an acute inpatient psychiatric admission.
2. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending psychiatrist within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Caretakers/guardians/family members should be included in the evaluation process, unless there are specific contraindications to their involvement.
3. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment, including, but not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
4. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.

C. Continuing Care Criteria (All criteria are required to consider for admission)

1. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - The persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
 - The emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or
 - A severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a psychiatrist.
2. The current treatment plan includes documentation of diagnosis (DSM-IV axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the family, facility of residence, personal caretakers and medical caretakers (unless there is an identified valid reason why such contact is not clinically appropriate or feasible). This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.
3. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion C1. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist.

***Additional Child/Adolescent Criterion** (*Must* be met for continuing care). Documented evidence of significant family involvement at least three times weekly **or** clearly documented evidence that such is medically or clinically contraindicated.

Adult Crisis Residential (Adult, Adolescent)*

(*Note:* Crisis Residential is a level of care tantamount to the acute level of care with the singular exception that the patient does not require 24-hour medical and nursing care, but may benefit from a 24-hour supervised, structured living arrangement for patients receiving partial hospitalization day treatment programming.)

A. Medical Necessity (*All* are required to consider for admission)

1. The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and the patient.

B. Admission Criteria (*All* criteria must be met to recommend admission)

1. The patient's mental condition requires a supervised, 24-hour setting and services to provide ongoing management with the potential for urgent referral, evaluation by a licensed mental health clinician and access to further medical services as needed.
2. Clinical documentation clearly indicates that the patient could not be treated safely at a lower level of care **or** that crisis residential programming could safely substitute for acute inpatient care.
3. The patient's psychosocial supports are severely limited such that the patient could not be maintained without clinical supervision outside the program.
4. The patient's condition requires multidisciplinary intervention for four (or more) hours daily, seven days per week.

C. Continuing Care Criteria (*All* criteria must be met to recommend continuing care)

1. Despite adequate treatment, the patient continues to exhibit signs and symptoms that led to the admission, or new problems have emerged that themselves meet the criteria for crisis residential admission.
2. The patient's problems must be clearly documented in the medical record, and there must be a progress note by the provider for each day of treatment.
3. There must be clear clinical documentation that transition of the patient to a lower level of care would result in exacerbation or re-emergence of symptoms sufficient to meet crisis residential admission criteria.

***Additional Child/Adolescent Criterion** — (*Must* be met to recommend continuing care). There is documented evidence of significant family involvement at least twice weekly **or** clear documentation that such is medically contraindicated.

Partial Hospitalization

Psychiatric Care (Adult, Child/Adolescent)*:

(*Note:* Partial Hospitalization [PHP] is a level of care tantamount to the acute level of care with the singular exception that the patient does not require 24-hour medical and nursing care. It is intended to be provided up to eight hours per day, up to seven times per week.)

A. Medical Necessity (*All* are required to consider for admission)

1. The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and the patient.

B. Admission Criteria (*All* criteria must be met to recommend admission)

1. The patient's mental condition requires skilled medical and nursing observation (e.g., serial mental status checks, medication administration, monitoring of vital signs) and is likely to improve with this intervention.
2. Clinical documentation clearly indicates that the patient could not be treated safely at a lower level of care **or** that partial hospitalization could safely substitute for acute inpatient care.
3. The patient's psychosocial supports are such that the patient can be supervised and maintained without clinical supervision for that period of time outside the program.
4. The patient's condition requires multidisciplinary intervention for four (or more) hours daily and more than three days per week.

C. Continuing Care Criteria (*All* criteria must be met to recommend continuing care)

1. Despite adequate treatment, the patient continues to exhibit signs and symptoms that led to the admission, or new problems have emerged that themselves meet the criteria for PHP admission.
2. The patient's problems must be clearly documented in the medical record, and there must be a progress note by the provider for each day of treatment.
3. There must be clear clinical documentation that transition of the patient to a lower level of care would result in exacerbation or re-emergence of symptoms sufficient to meet PHP admission criteria.

*Additional Child/Adolescent Criterion (*Must* be met to recommend continuing care).

There is documented evidence of significant family involvement at least twice weekly **or** clear documentation that such is medically contraindicated.

Intensive Outpatient Therapy Psychiatric Care (Adult, Child/Adolescent)*:

This level of care includes services at lesser levels of acuity than partial hospitalization. It is intended to be provided less than four hours daily but may be offered up to seven days weekly.

A. Medical Necessity (*All* are required to consider for treatment)

1. The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and the patient.

B. Admission Criteria (*All* criteria must be met to recommend treatment)

1. There is documentation of significant and acute deterioration in social, occupational, educational or family functioning.
2. The proposed treatment plan addresses the signs and symptoms consistent with the observed deterioration in functioning.
3. The patient's condition will benefit from the proposed intervention.
4. There is at least moderate impairment (a GAF less than 70).

C. Continuing Care Criteria (*All* criteria must be met to recommend continuing care)

1. The patient continues to exhibit signs and symptoms consistent with admission criteria.
2. The treatment plan reflects ongoing interventions to alleviate these impairments.
3. Clinical documentation supports that attempts to transition to a lower level of care would likely result in decompensation or exacerbation of the illness.

***Additional Criterion for Children/Adolescents:** There is clear documented evidence of significant family involvement with and adherence to treatment **or** clear evidence that this is medically contraindicated.

Outpatient Care

This level of care is the least intensive level of treatment and represents the majority of care delivered. Psychiatric medication management visits are typically 15 minutes in length. Individual psychotherapy sessions occur for up to 50-60 minutes and group psychotherapy sessions for up to 90 minutes. This service is conducted in an office setting.

A. Medical Necessity (*All* are required to consider for treatment)

1. The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional.
2. Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and the patient.

B. Admission Criteria (*All* must be met to recommend treatment)

1. As a consequence of a DSM-IV diagnosis, the individual is experiencing significant impairment in functioning in one or more of the following areas:
 - Social
 - Occupational
 - Educational
 - Family role
2. The proposed treatment plan is focused on:
 - Adaptive responses to present impairments
 - Clearly defined and measurable goals, and
 - A defined time frame
3. The patient has the requisite cognitive and emotional skills necessary to benefit from the proposed treatment plan.

C. Continuing Care Criteria (*All* must be met to recommend continuing care)

1. There is evidence that the patient is working to complete treatment goals and is attending sessions as scheduled.
2. The patient continues to exhibit impairment (GAF <70) requiring further treatment.
3. The treatment plan clearly addresses the impairments necessitating ongoing care.
4. If the GAF is >70, the patient has a diagnosis of a persistent DSM-IV disorder that requires maintenance treatment to avoid recurrence of symptoms.

**Residential Treatment (RTC, Domiciliary Care)
Psychiatric Care (Child/Adolescent)**

(*Note:* Residential Treatment is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents who have long-term illnesses not likely to respond to short-term interventions. Programs should provide, in addition to diagnostic and treatment services, instruction and support toward attainment of basic living skills, which will enable them to live in the community upon discharge.)

A. Medical Necessity (*All* are required to consider for admission)

1. The child or adolescent has been diagnosed with a psychiatric disorder by a licensed mental health professional.
2. Symptoms of this illness accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (DSM-IV).
3. The diagnosis must have been arrived at prior to admission in a face-to-face encounter between the professional and the patient.

B. Admission Criteria (*All* must be met to recommend admission)

1. There is clear clinical evidence that the child/adolescent has a severe mental illness that requires a level of intensity of services not available in the community.
2. The illness or disorder is likely to improve with active treatment.
3. Without this intervention, there is clear evidence that the child/adolescent will likely decompensate and represent a proximal risk of serious harm to self or others.

C. Continuing Care Criteria (*All* must be met to recommend continuing care)

1. The patient continues to exhibit signs and symptoms consistent with admission criteria.
2. There is a complete, multidisciplinary, individualized treatment plan, which includes input from the patient and family.
3. The treatment plan defines clear, measurable objectives leading to a goal of return to the community.
4. There is documented evidence of active psychiatric care, which is symptom-focused and specific to the child's/adolescent's diagnosis.
5. There is documented evidence of active family therapy at least weekly **or** clearly documented evidence that such is either impossible or medically contraindicated.

Definitions for Levels of Care: Substance Use Disorders

Priority Health recognizes the following as distinct levels of care and follows the ASAM PPC-2R for authorization decision making.

▶ **Inpatient Detoxification** — Detoxification services provided in an inpatient setting with full skilled nursing and medical care. Generally, services are provided on inpatient or sub-acute units. They can also be provided on a medical/surgical unit or other medical hospital unit when needed for safety or in the absence of adequate services elsewhere.

▶ **Inpatient Rehabilitation** — Care provided at an inpatient facility or sub-acute level with skilled nursing care after a patient has fully or partially recovered from acute detoxification symptoms and no longer requires intensive medical monitoring. These services can be provided in intermediate care facilities (ICFs) or have other licensing designations that may vary by state.

▶ **Residential Treatment** — Twenty-four-hour-per-day supervised care for a substance use disorder diagnosis not requiring full nursing and medical services.

▶ **Outpatient/Ambulatory Detoxification** — Detoxification services delivered within a structured program having medical and nursing supervision where physiological consequences of substance withdrawal do not have life-threatening potential.

▶ **Partial Hospital** — An intensive, non-residential level of care where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to an inpatient setting, meeting for more than four hours (and, generally, less than eight hours) daily. Such care is appropriate for substance use disorder treatment when provided in conjunction with ambulatory detoxification or when medical co-morbidity or other complications make less intensive levels of care unsafe or inadequate.

▶ **Intensive Outpatient**— Multidisciplinary, structured services provided at a frequency of up to four hours daily, up to five days per week, for the treatment of a substance use disorder.

▶ **Outpatient** — The least intensive level of service, provided in an office setting. Individual psychotherapy sessions occur for up to 60 minutes per day and group psychotherapy sessions for up to 90 minutes per day.

Supporting Documentation

- ASAM Treatment Guidelines, ASAM PPC-2R, 2001.
- APA Practice Guidelines for Substance Use Disorders, 05/2006.
- APA practice Guidelines for the Treatment of Acute Stress Disorder And Post-Traumatic Stress Disorder, 11/2004.
- APA Practice Guidelines for the Treatment of Alzheimer’s Disease and Other Dementias, 10/2007.
- APA Practice Guidelines for the Treatment of Bipolar Disorder, 11/2005.
- APA Practice Guidelines for the Treatment of Borderline Personality Disorder, 03/2005.
- APA Practice Guidelines for the Treatment of Eating Disorders, 05/2006.
- APA Practice Guidelines for the Treatment of Major Depressive Disorder, 03/2005.
- APA Practice Guidelines for the Treatment of Panic Disorder, 04/2006.
- APA Practice Guidelines for the Treatment of Schizophrenia, 04/2004.
- APA Practice Guidelines for the Treatment of Suicidal Behaviors, 11/2003.
- APA Practice Guidelines for the Psychiatric Evaluation of Adults, 05/2006.

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