

INPATIENT SERVICES

Inpatient Mental Health Services (Adult/Child/Adolescent)

Acute Inpatient Mental Health Services represent the most intensive level of psychiatric care and is delivered in a licensed hospital setting. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed, and psychiatrically-supervised treatment environment. Twenty-four hour skilled nursing care, daily medical care, and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize Members who display acute psychiatric conditions associated with a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the Member poses a significant danger to self or others, or displays severe psychosocial dysfunction. Special treatment may include physical, chemical, and mechanical restraint, seclusion, and a locked unit. Active family/guardian/natural supports involvement is important unless contraindicated. Frequency should occur based on individual needs.

Criteria

Admission Criteria

The following criterion is necessary for admission:

1. The Member demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention.

At least one of the following criteria (2-13) also must be met as evidence of actual or potential danger to self or others or severe psychosocial dysfunction:

2. A suicide attempt that is serious by degree of lethality and intentionally or suicidal ideation with a plan and means. Impulsive behavior and/or concurrent intoxication increase the need for consideration of this level of care. However, up to 24 hour observation may be used initially to rule out presence of acute psychiatric symptomatology and/or as a result of intoxication. Assessment should include an evaluation of:
 - a. the circumstances of the suicide attempt or ideation;
 - b. the method used or contemplated;
 - c. statements made by the individual;
 - d. the presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses; and
 - e. availability of responsible support systems.
3. Presence of suicidal/homicidal ideation when associated with: a suicide/homicide plan, means and intent, command hallucinations, delusions of guilt, prolonged intractable pain, fantasies of impending death, feelings of desperation or helplessness, impulsivity, or other indicators of suicidal/homicidal intent;
4. Current assaultive threats or behavior, resulting from an Axis I disorder, with a clear risk of escalation or future repetition (i.e., has a plan and means);
5. Recent history immediately prior to admission, prompting evaluation or intake, of significant self-mutilation (non-chronic), significant risk-taking, or loss of impulse control resulting in danger to self or others;
6. Recent history immediately prior to admission, prompting evaluation or intake of violence, resulting from an Axis I or Axis II disorder;
7. Command hallucinations directing harm to self or others;
8. Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the Member

	<p>cannot function at a less intensive level of care;</p> <p>9. Disorientation, judgment or memory impairment that is due to an Axis I or II disorder and accompanied by severe agitation, endangering the welfare of the Member or others;</p> <p>10. The adult Member manifests a disability in social, interpersonal, occupational, and/or educational functioning so severe that it is leading to dangerous or life-threatening functioning and can only be addressed in an acute inpatient setting;</p> <p>11. The child/adolescent Member manifests a severe, sustained, and pervasive inability to attend to age-appropriate responsibilities and/or experiences severe deterioration of family and work/school functioning, and no other level of care would be intensive enough to evaluate and treat the disorder;</p> <p>12. Inability in an age-appropriate manner to maintain adequate nutrition or self-care due to a psychiatric disorder, and family/community support cannot be relied upon to provide essential care; or</p> <p>13. The Member has experienced severe or life-threatening side effects from therapeutic psychotropic drugs.</p> <p><i>In addition, the following criterion must be met:</i></p> <p>14. The reason for admission to an inpatient level of care needs to clearly state the benefits the Member will receive in the program, and the goals of treatment cannot be based solely on the need for structure and lack of supports.</p>
Psychosocial, Occupational, and Cultural and Linguistic Factors	<i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions</i>
Exclusion Criteria	<p><i>Any of the following criteria (1-3) is sufficient for exclusion from this level of care:</i></p> <p>1. The Member can be safely maintained and effectively treated at a less intensive level of care;</p> <p>2. Medical evaluation reveals a physical condition that warrants a medical/surgical setting for treatment; or</p> <p>3. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.</p>
Continued Stay Criteria	<p><i>All of the following criteria (1-11) are necessary for continuing treatment at this level of care:</i></p> <p>1. The Member's condition continues to meet admission criteria for inpatient care, acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate;</p> <p>2. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are:</p> <ol style="list-style-type: none"> permanent cognitive dysfunction without acute Axis I or II diagnosis; primary substance use disorder requiring treatment in a specialized level of care; medical illness requiring treatment in a medical setting; impairments with no reasonable expectation of progress toward

	<p>treatment goals at this level of care; and</p> <p>e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning.</p> <p>3. The multidisciplinary discharge planning process starts from the assessment and tentative plan upon admission and includes the Member and family/guardian/natural support system as appropriate unless contraindicated, secondary to risk of harm to the Member or family/support;</p> <p>4. Treatment planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Family sessions need to occur routinely and in a timely manner. Expected benefit from all relevant treatment modalities, including family and group treatment, is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities;</p> <p>5. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;</p> <p>6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident;</p> <p>7. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the treatment and discharge plans;</p> <p>8. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated;</p> <p>9. The Member is actively participating in the plan of care and treatment to the extent possible consistent with the Member's condition;</p> <p>10. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; and</p> <p>11. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate care continue.</p>
<p>Discharge Criteria</p>	<p><i>Any of the following criteria (1-7) is sufficient for discharge from this level of care:</i></p> <p>1. The Member no longer meets admission criteria or meets criteria for a less intensive level of care;</p> <p>2. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care. Follow-up aftercare appointment is arranged for a time frame consistent with the Member's condition and applicable MBHP standards;</p> <p>3. The Member, parents, and/or legal guardian are not engaged in treatment or in following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a</p>

	<p>court has denied a request to issue an order for involuntary inpatient treatment;</p> <ol style="list-style-type: none">4. Consent for treatment is withdrawn, and either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment;5. Support systems that allow the Member to be maintained in a less restrictive treatment environment have been secured;6. The Member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or7. The Member's physical condition necessitates transfer to a medical facility.
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INPATIENT SERVICES

Inpatient Eating Disorder Services (Adult and Adolescent)

Inpatient eating disorder service is a 24-hour, staff-secure, hospital-based treatment program. The program provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program. In addition to all clinical services consistent with inpatient mental health treatment, the program provides clinical expertise and intervention specifically pertaining to eating disorders.

This is an addendum to general Inpatient Mental Health Services. All Inpatient Mental Health Services criteria for admission, exclusion, continued stay and discharge apply to this level of care as well as the specific criteria listed below.

Criteria

Admission Criteria

*In addition to the criteria listed above for general Inpatient Mental Health admission, **both** of the following criteria (1-2) are necessary for admission to this level of care:*

1. Member demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) eating disorder diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention; and
2. Member requires supervision during and after all meals/snacks and bathroom use to prevent caloric restriction, purging, and compulsive exercise.

*In addition, **one** of the following criteria (3-6) is necessary for admission to this level of care:*

3. As a result of voluntary caloric restriction and/or purging behavior (uncontrolled use of laxatives, diuretics, diet pills, vomiting, exercise, or insulin abuse), the Member is <75% of normal body weight or weight decline is acute, even if not <75% of normal body weight;
4. As a result of voluntary caloric restriction and or purging behavior (uncontrolled use of laxatives, diuretics, diet pills, vomiting, and exercise or insulin abuse), the Member has developed medical complications defined by one of the following criteria:
 - A. Medically unstable vital signs (seriously impaired) as evidenced by any one of the following:
 - a. ECG with acute changes from electrolyte disturbance, ischemia, or other cause
 - b. Hypotension - BP systolic < 80 mm Hg resting and supine;
 - c. Orthostatic changes in vital signs with symptoms
 - i. BP systolic drop of 10 mm Hg or more from supine to standing (waiting 3 minutes after position change)
 - ii. Pulse increase of 20 bpm or more from supine to standing (waiting 3 minutes after position change)
 - d. Body temperature < 35.5 C or 96 F
 - B. **Seriously abnormal lab value** – as evidenced by any one of the following - (assumes no underlying etiology from another chronic illness unrelated to the eating disorder):
 - a. Na+ <125 mEq/L
 - b. K+ <3.0 mEq/L

	<ul style="list-style-type: none"> c. C1 <86 mEq/L d. CO2 <20 or >35 mEq/L e. BUN >25 f. Serum creatinine >2.0 g. AST > 50 h. ALT > 55 i. Albumin < 3.0 j. Phosphorus - Age 10-20: < 3.4 or Age > 20: < 2.5 k. Magnesium < 1.5 l. Calcium < 8.0 or > 10.7 m. Glucose < 60 <p>C. <i>Serious arrhythmia</i></p> <ul style="list-style-type: none"> a. Any degree of heart block (after 24 hours of telemetry monitoring) b. Junctional bradycardia c. Sinus bradycardia < 50 bpm d. Prolonged QTc and need for antipsychotic medications <p>D. <i>Dehydration 5-10%</i> as defined by decrease in skin turgor, increased respiratory rate, postural hypotension, high urine SG, delayed capillary refill of 1.5 to 3.0 seconds</p> <p>E. <i>Weight loss of 25% or more</i> of healthy weight or BMI equal to or below 16 kg/M2</p> <p>F. <i>Recent weight loss of > 9%</i> in less than 4 weeks</p> <p>G. <i>Serious medical complications</i> of an eating disorder that require intensive monitoring (intestinal atony with obstruction, nutritional anemia, impaired renal function, fluid imbalance, exercise-induced injury)</p> <p>H. Where there is evidence of <i>serious medical deterioration</i>, absolute nutritional requirements must be met immediately, such as during pregnancy or poorly controlled diabetes mellitus.</p> <p>5. Member exhibits extreme depression (not suicidal), anxiety, or OCD that makes it difficult for the patient to focus on eating-disorder treatment without 24-hour support; or</p> <p>6. Member exhibits one of the following eating disorder criteria:</p> <ul style="list-style-type: none"> A. <i>Multiple daily binge-purge behaviors</i> that significantly impair daily function as reflected by a GAF < 50-55; B. <i>Interruption of the binge-purge cycle is required</i> because critically needed psychiatric or medically-related medication must be absorbed; C. <i>Acute food refusal</i> with clear indications of potential medical complications and no substantial chance for improvement without intensive treatment; or D. <i>Minimal weight restoration success, no success, or worsening of weight loss</i> with a lesser-structured level of care for at least three weeks if weight has not decreased or one to two weeks if weight continues to decrease while in treatment.
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<p>Exclusion Criteria</p>	<p><i>In addition to the exclusion criteria listed above for general Inpatient Mental Health Services, either of the following criteria (1-2) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. Co-existing acute psychiatric or substance use symptomatology may require a more restrictive treatment setting; or 2. The primary focus of treatment is not an active eating disorder.
<p>Discharge Criteria</p>	<p><i>In addition to the discharge criteria listed above for general Inpatient Mental Health Services, the following criterion is sufficient for discharge from this level of care:</i></p> <p>The Member has demonstrated an ability to eat appropriately outside the hospital, enabling higher potential for successful transition to a lower level of care.</p>

INPATIENT SERVICES

Inpatient Mental Health Services for Persons with Mental Retardation or Pervasive Developmental Disorder

Acute inpatient services for persons with mental retardation or pervasive developmental disorder are specialized hospital-based services for Members with co-existing mental retardation/pervasive developmental disorder and mental illness who require such service in discrete inpatient units that have been designated as specialty units. This inpatient treatment focuses on a behavioral approach and is provided by clinicians with specific training and expertise in treating this population. The goal of this specialty care is reflected in the definition for general inpatient mental health services. Special considerations as needed for the defined population are articulated in the following additional admission criteria.

This is an addendum to the general Inpatient Mental Health Services. All Inpatient Mental Health Services criteria for admission, exclusion, continued stay and discharge apply to this level of care as well as the specific criteria listed below.

Criteria

Admission Criteria

In addition to the criteria listed above for general Inpatient Mental Health Services admission, all of the following criteria (1-3) are necessary for admission:

1. The Member must have symptomatology consistent with a DSM-IV-TR Axis I diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
2. The Member has significant, below-average intellectual functioning with an IQ of approximately 70 or below, or meets criteria for pervasive developmental disorder; and
3. The Member demonstrates concurrent deficits or impairments in present adaptive functioning in at least two of the following areas:
 - a. Communication (limited expressive, receptive, or both)
 - b. Self-care
 - c. Home living
 - d. Social/interpersonal skills
 - e. Academic skills
 - f. Self-direction
 - g. Safety
 - h. Use of community resources
 - i. Work
 - j. Leisure
 - k. Health

In addition to the above, one or more of the following (4 through 8) must be present:

4. The Member has a new (above baseline) significant aggressive (to self or others) repetitive, or stereotyped behaviors that require continual close monitoring and intervention by staff who have had previous training and treatment experience with individuals with mental retardation/PDD in order to ensure Member and milieu safety;
5. The Member has a complex medical history or medication history with a multi-

	<p>medication regime and/or known sensitivities or adverse reactions to medication adjustment/changes, such that it warrants an evaluation by a psychiatrist with previous training and treatment experience with individuals with mental retardation/PDD and with an awareness of Department of Mental Retardation medication and psychotropic treatment planning regulations;</p> <ol style="list-style-type: none"><li data-bbox="511 367 1427 430">6. The Member has a consistent need for 1:1 assistance with activities of daily living, including personal hygiene;<li data-bbox="511 441 1427 598">7. The Member has a degree of intellectual impairment and vulnerability that warrants a need for services in a DMR/PDD specialty unit, <i>and</i> it can be determined that the Member would be at risk if hospitalized on a unit unable to address the specialized needs of a person with mental retardation/pervasive developmental disorder; or<li data-bbox="511 609 1427 674">8. The Member has a history of successful admissions only to a DMR/PDD specialty unit.
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INPATIENT SERVICES

Inpatient Substance Abuse Services (Level IV)

Inpatient Substance Abuse Services (Level IV Detoxification Services) provide a planned substance use program of 24-hour, medically managed evaluation, care, and treatment for individuals who are experiencing a severe withdrawal syndrome and/or acute biomedical complications as a result of a substance use disorder. Level IV services are typically rendered in a hospital facility that can provide life support in addition to 24-hour physician and nursing care. Daily individual physician contact is a required component of this level of care. A multidisciplinary staff of clinicians trained in mental health and addiction treatment and overall management of medical care are involved in the Member's treatment, and facilitate the conjoint treatment of co-existing biomedical and behavioral conditions.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, continued stay, exclusion and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level IV: Medically Managed Intensive Inpatient Services

INPATIENT SERVICES

Intensive Observation Beds up to 72 Hours

This level of care provides up to 72 hours of care in a secure and protected, medically staffed, psychiatrically supervised treatment environment that includes continuous nursing services and an on-site or on-call physician. Services are aimed at immediate collateral contact with the Member's community and outpatient service providers, with the goal of discharge in 72 hours or less. Members who are seriously mentally ill, have a chronic substance use disorder, or enrolled in MBHP Intensive Case Management are often referred to this program. The primary objective of this level of care is prompt evaluation and/or stabilization of Members presenting with acute psychiatric symptoms or distress. Before or at admission, a comprehensive assessment is conducted and a treatment plan developed. The treatment plan should emphasize crisis intervention services necessary to stabilize and restore the Member to a level of functioning that does not require hospitalization. Active family, guardian, and/or natural support involvement is provided unless contraindicated. This service is not appropriate for Members who are very likely to require services in an acute care setting exceeding 72 hours. Duration of services at this level of care may not exceed 72 hours, by which time stabilization and/or determination of the appropriate level of care will be made, with the treatment team facilitating appropriate treatment and support linkages. Admissions to 72-hour crisis observation beds are expected to occur seven days per week, 24 hours a day.

Criteria

Admission Criteria

All of the following (1-3) are necessary for admission to this level of care:

1. Symptoms consistent with a DSM-IV-TR (Axes I-V) diagnosis, which require and can reasonably be expected to respond to therapeutic intervention;
2. Indications that the symptoms may stabilize and an alternative treatment may be initiated within a 72-hour period. Past psychiatric history supports the need for rapid stabilization, collateral contact, and return to community services and supports; and
3. Presenting crisis cannot be safely evaluated or managed in a less restrictive setting.

In addition to the above, at least one of the following must be present:

4. Serious suicidal intent or a recent attempt with continued intent suggesting actual or potential danger to self as evidenced by the attempt's circumstances, the Member's statements, family and/or significant others reports, or intense feelings of hopelessness and helplessness;
5. Command auditory/visual hallucinations or delusions leading to suicidal or homicidal intent;
6. An indication of actual or potential danger to others as evidenced by a current threat;
7. Loss of impulse control leading to life-threatening behavior and/or other psychiatric symptoms that require immediate stabilization in a structured, psychiatrically monitored setting;
8. Substance intoxication with suicidal/homicidal ideation;
9. The Member is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning initiated by a specific cause, sudden event, and/or severe stressor; or
10. The Member demonstrates a significant incapacitating disturbance in mood/thought/ or behavior interfering with ADLs requiring immediate stabilization.

Psychosocial, Occupational, and Cultural and Linguistic Factors	<i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i>
Exclusion Criteria	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member can be safely maintained and effectively treated at a less restrictive level of care; 2. Threat or assault toward others is not accompanied by a DSM-IV-TR diagnosis; 3. Presence of any condition sufficiently severe to require acute psychiatric inpatient, medical, or surgical care; or 4. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
Continued Stay Criteria	<i>There are no continued stay criteria associated with 72-hour observation. By the end of 72 hours the Member must be transferred to a more or less intensive level of care.</i>
Discharge Criteria	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. Member no longer meets admission criteria or meets criteria for a less or more restrictive level of care; 2. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care. Follow-up aftercare appointment is arranged for a timeframe consistent with the Member's condition and applicable MBHP standards; 3. Length of stay at this level of care has surpassed the program's maximum 72-hour length of stay, and a plan for continuation of services at another level of care has been established; 4. The Member, parent, and/or legal guardian is competent but not engaged in treatment or in following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment; 5. Consent for treatment is withdrawn and either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment; 6. Support systems allowing the Member to be maintained safely in a less restrictive treatment environment have been secured; or 7. The Member's physical condition necessitates transfer to a medical facility.

INPATIENT SERVICES

Observation Beds up to 24 Hours

This level of care provides up to 24 hours of care in a secure and protected, medically staffed, psychiatrically supervised treatment environment that includes continuous nursing services and an on-site or on-call physician. The primary objective of this level of care is prompt evaluation and/or stabilization of Members presenting with acute psychiatric symptoms or distress. Before or at admission, a comprehensive assessment is conducted and a treatment plan developed. The treatment plan should emphasize crisis intervention services necessary to stabilize and restore the Member to a level of functioning that does not require hospitalization. This level of care may also be used for a comprehensive assessment to clarify previously incomplete Member information, which may lead to a determination of a need for a more intensive level of care. Active family, guardian, and/or natural support involvement is provided unless contraindicated. This service is not appropriate for Members who by history or initial clinical presentation are very likely to require services in an acute care setting exceeding 24 hours. Duration of services at this level of care may not exceed 24 hours, by which time stabilization and/or determination of the appropriate level of care will be made, with the treatment team facilitating appropriate treatment and support linkages. Admissions to 24-hour crisis observation beds are expected to occur seven days per week, 24 hours a day. Admission to this level of care is for voluntary admissions only. Members on an involuntary status who require extended observation will be authorized for a one-day inpatient admission.

Criteria

Admission Criteria

All of the following are necessary for admission to this level of care:

1. Symptoms consistent with a DSM-IV-TR (Axes I-V) diagnosis, which require and can reasonably be expected to respond to therapeutic intervention;
2. Indications that the symptoms may stabilize and an alternative treatment may be initiated within a 24-hour period;
3. Presenting crisis cannot be safely evaluated or managed in a less restrictive setting; and
4. The Member is willing to be admitted voluntarily.

In addition to the above, at least one of the following must be present:

5. Serious suicidal intent or a recent attempt with continued intent suggesting actual or potential danger to self as evidenced by the attempt's circumstances, the attempt, the individual's statements, family and/or significant others reports, or intense feelings of hopelessness and helplessness;
6. Command auditory/visual hallucinations or delusions leading to suicidal or homicidal intent;
7. An indication of actual or potential danger to others as evidenced by a current threat;
8. Loss of impulse control leading to life-threatening behavior and/or other psychiatric symptoms that require immediate stabilization in a structured, psychiatrically monitored setting;
9. Substance intoxication with suicidal/homicidal ideation;
10. The Member is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning initiated by a specific cause, sudden event, and/or severe stressor; or
11. The Member demonstrates a significant incapacitating disturbance in mood, thought, or behavior interfering with activities of daily living requiring immediate stabilization.

Psychosocial, Occupational, and Cultural and Linguistic Factors	<i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i>
Exclusion Criteria	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member can be safely maintained and effectively treated at a less intensive level of care; 2. Threat or assault toward others is not accompanied by a DSM-IV-TR diagnosis; 3. Presence of any condition sufficiently severe to require acute psychiatric inpatient, medical, or surgical care; or 4. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
Continued Stay Criteria	<i>There are no continued stay criteria associated with 24-hour observation. By the end of 24 hours the Member must be transferred to a more or less intensive level of care.</i>
Discharge Criteria	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. Member no longer meets admission criteria or meets criteria for less or more restrictive level of care; 2. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care. Follow-up aftercare appointment is arranged for a timeframe consistent with the Member's condition and applicable MBHP standards; 3. Length of stay at this level of care has surpassed the program's maximum 24-hour length of stay, and a plan for continuation of services at another level of care has been established; 4. The Member, parent, and/or legal guardian is competent but not engaged in treatment or is not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment; 5. Consent for treatment is withdrawn. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment; 6. Support systems allowing the Member to be maintained safely in a less restrictive treatment environment have been secured; or 7. The Member's physical condition necessitates transfer to a medical facility.

DIVERSIONARY SERVICES

Community-Based Acute Treatment (CBAT) (Child/Adolescent)

Community Based Acute Treatment (CBAT) is provided to children/adolescents who require a 24-hour-a-day, seven-day-a-week staff-secure (unlocked) group setting. For children and adolescents with serious behavioral health disorders, CBAT provides therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. CBAT services are provided in the context of a comprehensive, multidisciplinary, and individualized treatment plan that is frequently reviewed and updated based on the Member's clinical status and response to treatment. Intensive therapeutic services include, but are not limited to, daily medication monitoring; psychiatric assessment; nursing availability; specializing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing as needed. Active family/caregiver involvement through family therapy, a key element of treatment, is expected. Discharge planning should begin at admission, including plans for reintegration into the home, school, and community. If discharge to home/family is not an option, alternative placement must be rapidly identified with regular documentation of active efforts to secure such placement.

CBAT may be used as an alternative to, or transition from, inpatient services.

Criteria

Admission Criteria	<p><i>All of the following criteria are necessary for admission:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent demonstrates symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention; 2. The child/adolescent is experiencing emotional or behavioral problems in the home, school, community, and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment; 3. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the child/adolescent's needs; 4. The family situation and functioning levels are such that the child/adolescent cannot currently remain in the home environment and receive outpatient treatment; and 5. The child/adolescent is able to function with some independence and participate in community-based activities structured to develop skills for functioning outside of a controlled psychiatric environment.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent exhibits severe suicidal, homicidal, or acute mood symptoms/thought disorder, which require a more intensive level of care; 2. Parent/guardian does not voluntarily consent to admission or treatment; 3. The child/adolescent can be safely maintained and effectively treated at a less

	<p>intensive level of care;</p> <ol style="list-style-type: none"> 4. The child/adolescent has medical conditions or impairments that would prevent beneficial utilization of services; 5. The primary problem is not psychiatric. It is a social, legal, or medical problem, without a concurrent major psychiatric episode meeting criteria for this level of care; or 6. The admission is being used as a convenience or as an alternative to placement within the juvenile justice or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or simply as respite or housing.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent's condition continues to meet admission criteria at this level of care; 2. The child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. primary substance use disorder requiring treatment in a specialized level of care c. medical illness requiring treatment in a medical setting d. impairment with no reasonable expectation of progress toward treatment goals at this level of care e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Treatment planning is individualized and appropriate to the child/adolescent's age and changing condition, with realistic, specific, and attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been updated and implemented with consideration of all applicable and appropriate treatment modalities; 5. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice; 6. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address the lack of progress; 7. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes; 8. An individualized discharge plan has been developed that includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place, but discharge criteria have not yet been met; 9. The child/adolescent is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the child/adolescent's engagement in treatment.

	<ol style="list-style-type: none"> 10. Unless contraindicated, family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 11. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; and 12. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.
Discharge Criteria	<p><i>The following criteria (1-2) are necessary for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent can be safely treated at an alternative level of care; and 2. An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place. <p><i>One of the following criteria (3-8) is also necessary for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 3. The child/adolescent no longer meets admission criteria, or meets criteria for a less or more intensive level of care; 4. The child/adolescent's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at an alternate level of care; 5. The child/adolescent, parent, and/or legal guardian is competent but not engaged in treatment or is not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the child/adolescent does not meet criteria for an inpatient level of care; 6. Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care; 7. The child/adolescent is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of function; or 8. The child/adolescent's physical condition necessitates transfer to a medical facility.

DIVERSIONARY SERVICES

Intensive Community-Based Acute Treatment (ICBAT) (Child/Adolescent)

Intensive Community-Based Acute Treatment (ICBAT) provides the same services as Community-Based Acute Treatment (CBAT) but of higher intensity, including more frequent psychiatric evaluation and medication management and a higher staff-to-patient ratio. ICBAT is an alternative to inpatient hospitalization and is not used as a step-down placement following discharge from a locked, 24-hour setting.

This is an addendum to Community-Based Acute Treatment (CBAT). All CBAT criteria for admission, exclusion, continued stay and discharge apply to this level of care as well as the specific criteria listed below

Criteria

Admission Criteria	Criteria
	<p><i>In addition to the above criteria for CBAT level of care, one of the following criteria (1-5) is necessary for admission to ICBAT level of care, and the Member must be able to be safely contained in a staff-secure setting:</i></p> <ol style="list-style-type: none"> 1. There is an indication of actual or potential danger to others or self as evidenced by at least one of the following: <ol style="list-style-type: none"> a. Suicidal or homicidal ideation with plan; b. Documented history of violence; c. Command hallucinations; d. Persecutory delusions; or e. Recent history of fire-setting or sex-offending behavior. 2. There is an indication of potential (not imminent) danger to others as evidenced by at least one of the following: <ol style="list-style-type: none"> a. Documented current threat to kill or injure an identified person known to the individual; b. Documented current threat to kill or injure someone not directly associated with the individual; or c. Documented threat with plan but without readily accessible means to kill or injure someone and no specific target identified. 3. A recent serious suicide/homicide attempt and continued significant suicidal/homicidal intent as indicated by the circumstances of the attempt, method used, statements of the individual, or continuing feelings of helplessness and/or hopelessness; 4. A recent suicide/homicide gesture without the above indicators, with a history of previous significant attempts, accompanied by a severely depressed mood, occurrence of significant losses, or with continuing significant suicidal/homicidal intent; or 5. Impairment to the degree that the Member manifests major disability in social, interpersonal, occupational, and /or educational function and is not responsive to treatment and/or management efforts at a less intensive level of care.

DIVERSIONARY SERVICES

Crisis Stabilization Unit (Adult/Child/Adolescent)

This level of care is a facility- or community-based program where individuals with an urgent/emergent need can receive crisis stabilization services in a staff-secure, safe, structured setting that is an alternative to hospitalization. It provides continuous 24-hour observation and supervision for individuals who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from a short-term, structured stabilization setting. Services at this level of care include crisis stabilization, initial and continuing bio-psychosocial assessment, care management, medication management, and mobilization of family/guardian/natural supports and community resources. Some of the functions, such as medication management, administration, and physical care, will require access to medical services while other services can be provided by mental health professionals. The primary objective of the crisis stabilization service is to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that requires a less restrictive level of care. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated; frequency should occur based on individual needs.

Criteria

Admission Criteria

All of the following criteria (1-5) are necessary for admission to this level of care:

1. The individual demonstrates active symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis, which requires and can reasonably be expected to respond to intensive, structured intervention within a brief period of time;
2. An adult demonstrates a significant incapacitating disturbance in mood/thought/behavior, interfering with activities of daily living so that immediate stabilization is required;

OR

A child/adolescent is experiencing emotional or behavioral problems in the home, school, community and/or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a 24-hour therapeutic environment;

3. Clinical evaluation of the individual's condition indicates recent significant decompensation with a strong potential for danger to self or others, and the individual cannot be safely maintained in a less restrictive level of care;
4. The individual requires 24-hour observation and supervision but not the constant observation of an inpatient psychiatric setting except when being used as an alternative to an inpatient level of care; and
5. Clinical evaluation indicates that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame.

One of the following criteria (6-7) is also necessary for admission to this level of care:

6. A less intensive or restrictive level of care has been considered or tried; and
7. Clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care. It is reasonably expected that a short-term crisis stabilization period in a safe and supportive environment will ameliorate the individual's

	symptoms.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i>
Exclusion Criteria	<p><i>Any of the following criteria (1-6) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting; 2. The individual's medical condition is such that it can only be safely treated in a medical setting; 3. The individual/parent/guardian does not voluntarily consent to admission or treatment; 4. The individual can be safely maintained and effectively treated in a less intensive level of care; 5. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care; or 6. Admission is being used for purposes of convenience or as an alternative to incarceration, protective services, specialized schooling, or simply as respite or housing.
Continued Stay Criteria	<p><i>All of the following criteria (1-11) are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual's condition continues to meet admission criteria at this level of care; 2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate or is available; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. primary substance use disorder requiring treatment in a specialized level of care c. medical illness requiring treatment in a medical setting d. impairment with no reasonable expectation of progress toward treatment goals at this level of care e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Care is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan; 5. Treatment planning is individualized and appropriate to the individual's age and changing condition, with realistic, specific, and attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless

	<p>contraindicated. Family sessions need to occur routinely and in a timely manner. Expected benefit from all relevant treatment modalities, including family and group treatment, is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities;</p> <ol style="list-style-type: none"> 6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident; 8. The individual is actively participating in treatment to the extent possible consistent with the individual's condition; 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; 11. There is documented active discharge planning starting with admission; and 12. There is documented active coordination of care with behavioral health providers, the primary care clinician (PCC), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.
<p>Discharge Criteria</p>	<p><i>Any of the following criteria (1-6) is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual no longer meets admission criteria or meets criteria for a less or more intensive level of care; 2. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care. Follow-up aftercare appointment is arranged for a time frame consistent with the individual's condition and applicable MBHP standards; 3. The individual, parent, and/or legal guardian is not engaged in treatment or is not following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment; 4. Consent for treatment is withdrawn and, either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment; 5. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured; 6. The individual is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or 7. The individual's physical condition necessitates transfer to a medical facility.

DIVERSIONARY SERVICES

Partial Hospitalization Program (PHP) (Adult/Child/Adolescent)

Partial hospitalization is a nonresidential treatment program that may or may not be hospital-based. The program provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance abuse evaluation and counseling, and behavioral plans. The environment at this level of treatment is highly structured, and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services, professional monitoring, control, and protection. Psychiatric partial hospital treatment may be appropriate when a Member does not require the more restrictive and intensive environment of a 24-hour inpatient setting but does need up to eight hours of clinical services. Partial hospitalization is used as a time-limited response to stabilize acute symptoms. As such, it can be used both as a transitional level of care (i.e., step-down from inpatient) as well as a stand-alone level of care to stabilize a deteriorating condition and avert hospitalization. Treatment efforts need to focus on the Member's response during treatment program hours, as well as the continuity and transfer of treatment gains during the Member's non-program hours in the home/community. Family/guardian/natural supports involvement from the beginning of treatment is important unless contraindicated. Frequency should occur based on individual needs.

Criteria

Admission Criteria

All of the following criteria(1-6) are necessary for admission:

1. The Member demonstrates symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
 2. There is evidence of the Member's capacity for reliable attendance at the partial hospital program;
 3. There is an adequate social support system available to provide the stability necessary for maintenance in the program,
- OR
- The adult Member demonstrates willingness to assume responsibility for his/her own safety outside program hours;
4. There may be a risk to self or others or an inability to care for self that is not so serious as to require 24-hour medical/nursing supervision, but does require structure and supervision for a significant portion of the day and may require family/community support when away from the partial hospital program;
 5. The Member's condition requires a comprehensive, multi-disciplinary, multi-modal course of treatment, including routine medical observation/supervision to effect significant regulation of medication and/or routine nursing observation and behavioral intervention to maximize functioning and minimize risks to self or others; and
 6. The treatment plan needs to clearly state what benefits the Member can reasonably expect to receive in the program; the goals of treatment cannot be based solely on need for structure and lack of supports.

<p>Psychosocial, Occupational, and Cultural and Linguistic Factors</p>	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
<p>Exclusion Criteria</p>	<p><i>Any of the following criteria (1-8) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member is an active or potential danger to self or others or a sufficient impairment exists so that a more intense level of service is required; 2. The Member does not voluntarily consent to admission or treatment; 3. The Member has medical conditions or impairments that would prevent beneficial utilization of services; 4. The Member requires a level of structure and supervision beyond the scope of the program; 5. The Member can be safely maintained and effectively treated at a less intensive level of care; 6. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration; 7. The focus of treatment is primarily for peer socialization and group support; or 8. The family/guardian or support system refuses to be involved in the child/adolescent Member's treatment.
<p>Continuing Stay Criteria</p>	<p><i>All of the following criteria (1-10) are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member's condition continues to meet admission criteria at this level of care; 2. The Member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. primary substance use disorder requiring treatment in a specialized level of care c. medical illness requiring treatment in a medical setting d. impairment with no reasonable expectation of progress toward treatment goals at this level of care e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the treatment and discharge plans; 5. Treatment planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian and/or other support systems unless

	<p>contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities;</p> <ol style="list-style-type: none"> 6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident; 8. The Member is actively participating in the plan of care and treatment to the extent possible consistent with the Member's condition; 9. Unless contraindicated the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been evaluated and/or prescribed; 11. There is documented active discharge planning from the beginning of treatment; and 12. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.
<p>Discharge Criteria</p>	<p><i>Any of the following criteria (1-7) is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care; 2. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care; 3. The Member, family, and/or legal guardian is not engaged in treatment or is not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment; 4. Consent for treatment is withdrawn, and either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied a request to issue an order for involuntary inpatient treatment; 5. Support systems, which allow the Member to be maintained in a less restrictive treatment environment, have been secured; or 6. The Member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.

DIVERSIONARY SERVICES

Partial Hospitalization Program (PHP) for Eating Disorders (Adult and Adolescent)

Partial Hospital Program (PHP) for Eating Disorders is a nonresidential treatment program that may or may not be hospital-based. The program provides clinical diagnostic and treatment services on a level of intensity equal to a general mental health PHP. In addition to all clinical services consistent with PHP, the program provides clinical expertise and intervention specifically pertaining to eating disorders.

This is an addendum to the general Partial Hospitalization Program. All Partial Hospitalization Program criteria for admission, exclusion, continued stay and discharge apply to this level of care as well as the specific criteria listed below.

Criteria

Admission Criteria

In addition to the admission criteria for general Partial Hospitalization Program, all of the following criteria (1-3) are necessary for admission to this level of care:

1. The Member demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) eating disorder diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
2. As a result of voluntary caloric restriction and/or purging behavior (uncontrolled use of laxatives, diuretics, diet pills, vomiting, exercise, or insulin abuse), the Member is less than 90 percent of normal body weight; and
3. The Member requires supervision during and after all meals, snack, and bathroom use that could not be attained in a less intensive setting to prevent caloric restriction, purging, and compulsive exercise.

DIVERSIONARY SERVICES

Family Stabilization Team (FST) Program

The Family Stabilization Team (FST) program provides intensive, therapeutic services in the home setting to assist the family in stabilizing children and adolescents during a period of emotional, behavioral, and/or psychiatric disturbance, and secondarily, after out-of-home treatment, such as inpatient hospitalization or community-based acute treatment. This type of program is designed to treat all members of a family, not just the specific child/adolescent identified as being at risk for continued inpatient care, residential treatment, and/or out-of-home placement. Services are designed to prevent repeated hospitalizations or to enable children/adolescents to move to the least restrictive setting as soon as it is clinically indicated, or to foster a successful family reunification. Treatment decisions must include consideration of the resiliency, strengths, and deficits of the child; the ability of the parents to provide the necessary advocacy for meeting the child's needs; and the ability of the parents to support individuation in the child. Goals of developing positive thoughts, necessary life skills, and strong self-esteem should be included.

Supportive services are delivered during an acute psychiatric episode or following out-of-home treatment (e.g., inpatient care). Programs at this level of care typically use a team approach with both licensed and/or certified professionals and paraprofessionals, delivering a flexible variety of services under a comprehensive and coordinated treatment plan. Services may include counseling, crisis intervention, case management, skill building, mentoring, and other non-traditional services. Family stabilization programs can be used as an independent level of care or as an adjunct to another level of care.

Criteria

Admission Criteria	<p><i>All of the following criteria are necessary for participation in this level of care:</i></p> <ol style="list-style-type: none"> 1. Child/adolescent demonstrates symptomatology consistent with DSM-IV-TR (Axes I-V) diagnosis, which requires, and can reasonably be expected to respond to therapeutic intervention; 2. Child/adolescent has had psychiatric inpatient or residential treatment admission or is at risk of being placed out of the home in a treatment facility; 3. Outpatient services are not sufficient to meet the family's needs for support and education; 4. Family is not receiving duplicative services from any other agency; 5. Child/adolescent and family members give consent and are motivated to participate in the program; and 6. Child/adolescent's clinical condition warrants this level of care to maintain the child/adolescent safely in the home and community.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. Child/adolescent's home environment presents safety risks to the staff making home visits; 2. Child/adolescent is at risk to harm self or others, or sufficient impairment exists that requires a more intensive level of care beyond community-based intervention;

	<ol style="list-style-type: none"> 3. Child/adolescent has medical conditions or impairments that would prevent beneficial utilization of services; or 4. The family is receiving duplicative supportive services and does not require this level of care.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are required for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. Clinical condition continues to warrant family stabilization services in order to maintain the child/adolescent in the community and continue progress toward treatment plan goals; 2. Child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. primary substance use disorder requiring treatment in a specialized level of care c. medical illness requiring treatment in a medical setting d. impairment with no reasonable expectation of progress toward treatment goals at this level of care e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes as described in the treatment and discharge plans; 5. Treatment planning is individualized and appropriate to the child/adolescent's age and changing condition, with realistic, specific, attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities; 6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible, consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident; 8. The child/adolescent is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition; 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; 11. There is documented active discharge planning from the beginning of treatment; and

	<p>12. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician) and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.</p>
<p>Discharge Criteria</p>	<p><i>Any of the following criteria are sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent no longer meets admission criteria, or meets criteria for a less or more intensive level of care; 2. The child/adolescent's treatment plan goals and objectives have been substantially met; 3. The child/adolescent, parent, and/or legal guardian are not engaged in treatment or in following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the child/adolescent, parent, and/or guardian has the capacity to make an informed decision, and the child/adolescent does not meet the criteria for a more intensive level of care; 4. Consent for treatment is withdrawn. In addition, it is determined that the child/adolescent, parent, and/or guardian has the capacity to make an informed decision, and the child/adolescent does not meet the criteria for a more intensive level of care; 5. The child/adolescent is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or 6. Support systems that allow the child/adolescent to be maintained in a less restrictive treatment environment have been secured.

DIVERSIONARY SERVICES

Community Support Program (CSP)

Community Support Programs (CSPs) provide an array of services delivered by a community-based, mobile, multidisciplinary team of paraprofessionals. These programs provide essential services to Members with a long-standing history of a psychiatric or substance abuse disorder and to their families, or to Members who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting.

In general, a Member who can benefit from CSP services has a disorder that has required hospitalization or has resulted in serious impairment with a risk of hospitalization. CSP services are used to prevent hospitalization. They are designed to respond to the needs of individuals whose pattern of utilization of services or clinical profile indicates high risk of readmission into 24-hour treatment settings. These services are designed to be maximally flexible in supporting individuals who are unable to independently access and sustain involvement with needed services. Services include:

- Assisting Members in enhancing their daily living skills;
- Providing service coordination and linkage;
- Assisting with obtaining benefits, housing, and health care;
- Developing a crisis plan;
- Providing prevention and intervention; and
- Fostering empowerment and recovery, including linkages to peer support and self-help groups.

These outreach and supportive services are directed toward adults, children, and adolescents and vary according to duration, type, and intensity of services depending on the changing needs of each individual. Community Support Services are expected to complement other services already in place for the individual.

This service is only available to Members who are enrolled in one of the following four Care Management programs at MBHP: Targeted Outreach, Care Coordination, Intensive Clinical Management (ICM), or Medical Care Management (MCM, or *Essential Care*). Exceptions may be made with the approval of MBHP management.

Criteria

Admission Criteria

All of the following criteria are necessary for admission to this level of care:

1. Member demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
- OR
2. Is referred by a primary care clinician for assistance with necessary medical follow-up.
 3. The Member is at risk for hospitalization or multiple hospitalizations, or the individual's health is at risk due to difficulty accessing or engaging in appropriate health care services;
 4. The Member does not have adequate family support and therefore needs external activities of daily living and social support in order to access and engage in services, remain stable outside of an inpatient environment, or

	<p>transition to independent living from a more restrictive setting;</p> <ol style="list-style-type: none"> 5. There has been a documented inability to sustain involvement with needed services, or there is evidence that a comprehensive integrated program of medical and psychosocial rehabilitation services are needed to support improved functioning at the least restrictive level of care; and 6. The Member and his/her parent/guardian, if appropriate, are willing to accept and cooperate with Community Support Program services.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i>
Exclusion Criteria	<p><i>Any of the following criteria may be sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member's home environment presents safety risks to the staff making home visits; 2. The Member is at risk to harm self or others, or sufficient impairment exists to require a more intensive level of service beyond community-based intervention; 3. The Member has medical conditions or impairments that would prevent beneficial utilization of services; or 4. The Member is receiving similar supportive services and does not require this level of care.
Continued Stay Criteria	<p><i>All of the following criteria are necessary for continuing in treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. Severity of illness and resulting impairment continue to warrant this level of care in order to maintain the Member in the community and continue progress toward treatment plan goals; 2. The Member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate or is available; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. primary substance use disorder requiring treatment in a specialized level of care c. medical illness requiring treatment in a medical setting d. impairment with no reasonable expectation of progress toward treatment goals at this level of care e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the treatment and discharge plans;

	<ol style="list-style-type: none"> 5. Treatment planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been updated and implemented with consideration of all applicable and appropriate treatment modalities; 6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are documented; 8. The Member is actively participating in the plan of care and treatment to the extent possible consistent with the Member's condition; 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; 11. There is documented active discharge planning starting with admission; and 12. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate care continue.
Discharge Criteria	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member no longer meets admission criteria or meets criteria for a less or more intensive level of care; 2. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care; 3. The Member, parent, and/or legal guardian is not engaged in treatment or is not following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member, parent, and/or guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 4. Consent for treatment is withdrawn. In addition, it has been determined that the Member, parent, and/or guardian has the capacity to make an informed

	<p>decision, and the Member does not meet the criteria for a more intensive level of care;</p> <ol style="list-style-type: none">5. Support systems that allow the Member to be maintained in a less restrictive treatment environment have been secured; or6. The Member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.
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OUTPATIENT DAY SERVICES

Psychiatric Day Treatment Program (Children/Adolescents and Adults)

Psychiatric Day Treatment provides a coordinated set of individualized, integrated, and therapeutic supportive services to Members with psychiatric disorders, who need more active or inclusive treatment than is typically available through traditional outpatient mental health services.

While less intensive than partial hospitalization, day treatment is an intensive, clinical program that includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a structured setting. Day treatment programs provide rehabilitative, pre-vocational, educational, and life-skill services to promote recovery and attain adequate community functioning, with focus on peer socialization and group support.

Day treatment assists Members in beginning the recovery and rehabilitation process and may provide supportive transitional services to Members who are no longer acutely ill, require moderate supervision to avoid risk, and/or are not fully able to re-enter the community or the workforce.

Providers should ensure that the Member has opportunities and support for involvement in community, social, and leisure-time programs, as well as opportunities to pursue personal, ethnic, and cultural interests. Services are usually provided in a community setting. A goal-directed treatment plan developed with the member and/or family will guide the course of treatment. Active family/significant other involvement is important unless contraindicated. Frequency should occur based on individual needs.

Enhanced Psychiatric Day Treatment has the same goals, structure, and modalities as Psychiatric Day Treatment with the addition of peer specialist services. The medical necessity criteria are the same for each of these day treatment programs.

All of the following medical necessity criteria for general Psychiatric Day Treatment Program apply to Enhanced Psychiatric Day Treatment Program.

Criteria

Admission Criteria	<p><i>All of the following criteria are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member demonstrates symptomatology consistent with a DSM-IV-TR (AXES I-IV) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention in a structured milieu and the activities of daily living; 2. The exacerbation or persistence of a longstanding psychiatric disorder results in symptoms of thought, mood, behavior, or perception that significantly impair functioning; and 3. The Member is capable of mastering more complex personal and interpersonal life skills..
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member is a risk to self or others, or sufficient impairment exists to require

	<p>a more intensive level of service;</p> <ol style="list-style-type: none"> 2. The Member can be safely maintained and effectively treated at a less intensive level of care; 3. The Member and/or guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment; 4. The Member requires a level of structure and supervision beyond the scope of the program; 5. The Member has medical conditions or impairments that would prevent beneficial utilization of services; or 6. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric diagnosis meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member's condition continues to meet admission criteria at this level of care; 2. The Member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. primary substance use disorder requiring treatment in a specialized level of care c. medical illness requiring treatment in a medical setting d. impairment with no reasonable expectation of progress toward treatment goals at this level of care e. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the discharge plan; 5. Treatment planning is individualized and appropriate to the Member's age and changing condition. Goals and objectives should be realistic, specific, and attainable and address the Member's need for structured daily activities. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been updated and implemented with consideration of all applicable and appropriate treatment modalities; 6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident; 8. The Member is actively participating in the plan of care and treatment to the extent possible consistent with the Member's condition;

	<ol style="list-style-type: none"> 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been evaluated and/or prescribed; 11. There is documented active discharge planning from the beginning of treatment; and 12. There is documented active coordination of care with other behavioral health providers and the PCC (primary care clinician) and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.
<p>Discharge Criteria</p>	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care; 2. The Member's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care; 3. The Member appears able to remain stable with a less intense level of services, including routine outpatient care, prescribed medications, and community-based support as needed; 4. The Member exhibits severe disruptive or dangerous behaviors that require stabilization at a more intensive level of care; 5. The Member, parent, and/or guardian is not engaged in treatment or is not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member, parent, and/or guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 6. Consent for treatment is withdrawn. In addition, it has been determined that the Member, parent, and/or legal guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 7. The Member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning; or 8. Support systems have been secured that allow the individual to be maintained in a less restrictive environment.

DIVERSIONARY SERVICES

Acute Treatment Services (ATS) for Substance Abuse

Acute Treatment Services (ATS) for Substance Abuse (Level IIIA Detoxification) shall mean 24-hour, seven-day-a-week, medically supervised addiction treatment that provides evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Members with co-occurring disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions, and pregnant women receive specialized services to ensure substance abuse treatment and obstetrical care. These services may be provided in licensed, freestanding, or hospital-based programs.

Acute Treatment Services are provided to Members experiencing, or at significant risk of developing, an uncomplicated withdrawal syndrome as a result of an alcohol and/or other substance use disorder. Members receiving ATS do not require the medical and clinical intensity of a hospital-based detoxification service, nor can they be effectively treated in a less intensive outpatient level of care.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

All of the medical necessity criteria for general ATS for Substance Abuse apply to Acute Treatment Services (ATS) for Pregnant Women.

Criteria

For admission, exclusion, continued stay, and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level III.7: Medically Monitored Inpatient Detoxification

DIVERSIONARY SERVICES

Enhanced Acute Treatment for Substance Abuse Services (E-ATS)

Enhanced Acute Treatment Services (E-ATS) for individuals with co-occurring mental health disorders provides diversionary and/or step-down opportunities for Members who require substance detoxification services through a planned program of 24-hour, medically monitored evaluation, care, and treatment, and whose co-occurring mental health disorder requires a 24-hour, medically monitored evaluation, care, and treatment program, including the prescribing and dosing of medications typically used for the treatment of mental health disorders. E-ATS services for individuals with co-occurring addiction and mental health disorders are typically rendered in a licensed acute care or community-based setting (e.g., licensed freestanding or hospital-based programs, or a licensed detoxification program) with 24-hour physician and psychiatrist consultation availability, 24-hour nursing care and observation, counseling staff trained in addiction and mental health treatment, and overall monitoring of medical care. Services are typically provided under a defined set of physician-approved policies, procedures, or clinical protocols.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, exclusion, continued stay, and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level III.7 Medically Monitored Intensive Inpatient Treatment*

*Additional Criteria

Admission Criteria

In addition to the ASAM admission criteria, all of the following criteria are necessary for admission:

1. The Member demonstrates symptoms consistent with DSM-IV-TR (Axes I-V) mental health and substance abuse/dependence diagnoses, which require and are likely to respond to intensive, structured intervention;
2. The Member has sufficient intellectual capacity to respond to active psychological treatment;
3. The Member is able to function with some independence and participate in community-based activities structured to develop skills for functioning outside of a controlled psychiatric environment;
4. The Member would require inpatient psychiatric hospitalization without access to these services;
5. The Member may have suicidal ideation, or a history of suicidal ideation, but has no actionable plan, and can be safely maintained in a highly structured, 24-hour therapeutic setting; and

	6. The Member may be stepped down from Acute Inpatient, Observation, or Level IV Detox level of care.
Exclusion Criteria	<p><i>In addition to the ASAM exclusion criteria, the following criterion may be sufficient for exclusion from this level of care:</i></p> <p>1. The Member has a psychiatric condition that might include safety issues of such severity that care can only be safely provided in an inpatient mental health level of care, or higher medical level of care.</p>
Continued Stay Criteria	<p><i>In addition to the ASAM continued stay criteria, all of the following criteria are necessary for continuing treatment at this level of care:</i></p> <p>1. The Member's condition continues to meet admission criteria at this level of care, and no less intensive level of care would be adequate;</p> <p>2. The Member and family (when appropriate) are participating, to the extent he or she and they are medically and psychologically capable, with a program that is considered adequate to alleviate the signs and symptoms justifying treatment; and</p> <p>3. When medically necessary, appropriate pharmacological intervention has been evaluated and prescribed.</p>
Discharge Criteria	<p><i>In addition to the ASAM discharge criteria, the following criterion is sufficient for discharge from this level of care:</i></p> <p>1. Consent for treatment is withdrawn. In addition, it has been determined that the Member has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.</p>

DIVERSIONARY SERVICES

Clinical Support Services for Substance Abuse

Clinical Support Services for Substance Abuse (Level IIIB Detoxification) shall mean 24-hour treatment, usually following Acute Treatment Services (ATS) for Substance Abuse, and including intensive education and counseling regarding the nature of addiction and its consequences, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

These programs provide multidisciplinary treatment interventions and emphasize individual, group, family, occupational, and other forms of therapy. Linkage to aftercare, relapse components, and self-help groups, such as AA and NA, are integrated into treatment and discharge planning.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, continued stay, exclusion and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level III.5: Clinically Managed High-Intensity Residential Treatment

OUTPATIENT DAY SERVICES

Intensive Outpatient Programs (IOP)

Intensive outpatient programs (IOP) provide time limited, multidisciplinary, multimodal structured treatment in an outpatient setting. Such programs are less intensive than a partial hospital program or day treatment (e.g., may not always include medical oversight and medication evaluation and management) but significantly more intensive than outpatient psychotherapy and medication management. This level of care is used to intervene in a complex or refractory clinical situation and should be differentiated from longer term, structured day programs intended to achieve or maintain stability for individuals with severe and persistent mental illness. Clinical interventions available should include modalities typically delivered in office-based settings, such as individual, couple, and family psychotherapy, group therapies, medication management, and psycho-educational services. Adjunctive therapies such as life-planning skills (assistance with vocational, educational, financial issues) and special issue or expressive therapies may be provided, but must be standardized in content or duration; that is, they must have a specific function within a given patient's treatment plan. Active family/natural supports involvement is important, unless contraindicated. Frequency should occur based on individual needs.

As functioning improves, the individual will receive a diminishing number of treatment hours. All treatment plans must be individualized and should focus on acute stabilization and transition to community outpatient treatment and support groups as needed. Although Members may present as subacute, the environment must be sufficiently staffed to allow rapid professional assessment of a change in mental status that warrants a shift to a more intensive level of care or a change in medication.

IOPs may be developed to address the unique needs of a special population. All of the following medical necessity criteria will apply to these specialized programs (i.e., IOP for Deaf and Hard of Hearing).

Criteria

Admission Criteria	<p><i>All of the following criteria are necessary for admission:</i></p> <ol style="list-style-type: none"> 1. The Member demonstrates symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention. Evaluation needs to include an assessment of substance abuse issues; 2. The Member's GAF score should be within the range of 31-60; 3. Treatment planning should be individualized and specifically state what benefits the Member can reasonably expect to receive; 4. There is an expectation that the Member will show significant progress toward treatment goals within the specified time frames as dictated by the individual treatment plan; 5. There are significant symptoms that interfere with the Member's ability to function in at least one life area; and 6. The Member's condition requires a coordinated, office-based treatment plan of services, which may require different modalities and/or clinical disciplines for progress to occur.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>

<p>Exclusion Criteria</p>	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member is a danger to self and others, or sufficient impairment exists that a more intensive level of service is required; 2. The Member has medical conditions or impairments that would prevent beneficial utilization of services; 3. The Member requires a level of structure and supervision beyond the scope of the program; 4. The Member can be safely maintained and effectively treated at a less intensive level of care; or 5. The primary problem is not psychiatric. It is a social, legal, or medical problem, without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member's condition continues to meet admission criteria at this level of care; 2. The Member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. medical illness requiring treatment in a medical setting c. impairment with no reasonable expectation of progress toward treatment goals at this level of care d. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Treatment planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities; 5. An active discharge planning process begins with the initial assessment and includes the patient, family, and/or significant other as appropriate; 6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident. The Member is active in treatment; 8. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the discharge plan; 9. There is documented active attempt at coordination of care with other behavioral health providers and the PCC (primary care clinician) and other

	<p>services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue; and</p> <p>10. When medically necessary, appropriate psychopharmacological intervention has been evaluated and/or prescribed.</p>
<p>Discharge Criteria</p>	<p><i>Any of the following criteria are sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member no longer meets admission criteria or meets criteria for a less or more intensive level of care; 2. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care; 3. The Member, parent, and/or legal guardian is non-participatory in treatment or is not following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member, parent, and/or legal guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 4. Consent for treatment is withdrawn. In addition, it has been determined that the Member, parent, and/or legal guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 5. Support systems that allow the Member to be maintained in a less restrictive treatment environment have been secured; or 6. The Member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care despite treatment planning changes.

OUTPATIENT DAY SERVICES

Program of Assertive Community Treatment (PACT) (Adult Only)

The Program of Assertive Community Treatment (PACT) is a multidisciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment; assertive outreach; rehabilitation; and support to individuals with serious mental illness. The program team provides assistance to individuals to maximize their recovery, ensures consumer-directed goal setting, assists individuals in gaining hope and a sense of empowerment, and provides assistance in helping individuals become better integrated into their community. The program provides biopsychosocial services for adults with serious mental illness who often have co-occurring disorders, such as substance abuse, and are homeless or are involved with the judicial system.

The team is the single point of clinical responsibility and assumes accountability for assisting individuals in getting their needs met while achieving their goals for recovery. The majority of services are provided directly by PACT team members in the individual's natural environment and are available on a 24-hour, seven-day a week basis. Services are comprehensive and highly individualized. They are modified as needed through an ongoing assessment and treatment planning process. Services vary in intensity based on the needs of the individuals served.

Criteria

Admission Criteria

All of the following criteria (1-4) are necessary for admission to this level of care:

1. The individual must be an adult, age 19 or older, who is either MBHP eligible and/or a DMH client on the date of service;
2. The individual must have an Axis I diagnosis as defined by the DSM-IV;
3. The individual has significant functional impairments as demonstrated by at least one of the following conditions:
 - a) inability consistently to perform practical daily living tasks (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; preparing meals; washing clothes; budgeting; or carrying out child-care responsibilities) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others (such as friends, family, or relatives)
 - b) inability to obtain consistent employment at a self-sustaining level
 - c) inability to maintain a safe living situation (e.g., repeated evictions or loss of housing)
 - d) non-responsive to the MBHP's Intensive Clinical Management services (not applicable for DMH clients)
 - e) two or more acute psychiatric hospital admissions or psychiatric emergency services per year
 - f) co-existing substance abuse disorder greater than six months duration
 - g) high risk or recent history of criminal justice involvement (e.g., arrest and incarceration)
 - h) residing in substandard housing, homeless, or at imminent risk of becoming homeless
 - i) currently admitted to an acute level of care or supervised

	<p>community residence but able to be discharged if intensive community support services are provided</p> <p>j) in danger of requiring acute level of care if more intensive services are not available</p> <p>k) inability to keep office-based appointments</p> <p>4. The individual and legal guardian, if appropriate, are willing to accept and cooperate with the PACT team.</p>
Psychosocial, Occupational, and Cultural and Linguistic Factors	<i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i>
Exclusion Criteria	<p><i>Any of the following criteria (1-6) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual has a diagnosis of a substance abuse disorder only; 2. The individual has a primary diagnosis of mental retardation; 3. The individual has a primary diagnosis of an organic disorder; 4. The individual is actively engaged in treatment in a Community Support Program; 5. The individual is at risk of harming self or others; or 6. The individual has an impairment that requires a more intensive level of service than community-based intervention.
Continued Stay Criteria	<p><i>All of the following criteria (1-5) are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. Severity of illness and resulting impairment continue to require this level of service; 2. Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives stated; 3. The mode, intensity, and frequency of treatment are appropriate; 4. Active treatment is occurring, and continued progress toward goals is expected; and 5. The individual and family (when appropriate and with consent) are participating to the extent capable with a program that is considered adequate to alleviate the signs and symptoms justifying treatment.
Discharge Criteria	<p><i>Any of the following criteria (1-3) is sufficient for discharge from this level of care;</i></p> <ol style="list-style-type: none"> 1. The individual's treatment plan and discharge goals have been substantially met; 2. Consent for treatment is withdrawn; or 3. The individual no longer meets the admission criteria or meets criteria for a less or more intensive level of care.

OUTPATIENT DAY SERVICES

Dialectical Behavioral Therapy (Adults and Adolescents)

Dialectical Behavior Therapy (DBT) is a structured outpatient treatment as defined by Marsha Linehan, PhD (Linehan, et. al., *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, New York: Guilford Press, 1993), which combines strategies from behavioral, cognitive, and other supportive psychotherapies. DBT services encompass individual therapy, DBT skills group, therapeutic consultation to the Member on the telephone, and the therapists' internal consultation meeting(s). Through an integrated treatment team approach to services, DBT seeks to enhance the quality of the Member's life through group skills training and individual therapy with a dialectical approach of support and confrontation.

DBT is available for adults who meet the DSM-IV diagnosis for borderline personality disorder and who exhibit chronic para-suicidal behaviors.

DBT is also available for adolescents who meet three of the nine DSM-IV criteria for borderline personality disorder and who exhibit suicidal or self-injurious behaviors.

Criteria

Admission Criteria	<p><i>All of the following criteria are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. All of the admission criteria for Outpatient Services; 2. The Member demonstrates symptomatology consistent with a borderline personality disorder diagnosis as described in the DSM-IV-TR (AXES I-V) and exhibits chronic para-suicidal behaviors; 3. Members must be age 13 or older; 4. Members under the age of 18 must meet three of the nine DSM IV criteria for borderline personality disorder and exhibit suicidal or self-injurious behaviors; 5. The Member displays willingness and the capacity to engage in a complex behavioral treatment; and 6. The Member's condition requires a coordinated, office-based treatment plan of services, which may require different modalities for progress to occur.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. All of the exclusion criteria for Outpatient Services; 2. The Member is such a serious risk to self or others, or sufficient impairment exists, that a more intensive level of structure and supervision beyond the scope of this program is required; or 3. The Member can be safely maintained and effectively treated at a less intensive level of care.

<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. All of the continuing stay criteria for outpatient services; 2. During the course of treatment, the Member and therapist form an oral or written contract addressing the Member's commitment to following the goals and ground rules of DBT-specific treatment; and 3. Ongoing assessment and review/reinforcement of ground rules and goals are worked on between the Member and therapist, as treatment indicates.
<p>Discharge Criteria</p>	<p><i>Any of the following criteria are sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. All of the discharge criteria for outpatient services; 2. Support systems have been thoroughly explored and/or secured, which allow the Member to be safe and to use DBT skills in a less restrictive treatment environment; or 3. There have been no improvements in para-suicidal behavior after one year, and other treatment alternatives have been put into place.

OUTPATIENT DAY SERVICES

Structured Outpatient Addiction Program (SOAP)

Structured Outpatient Addiction Program (SOAP) shall mean clinically intensive, structured, day and/or evening substance abuse services. These programs can be used as a transition service in the continuum of care for those individuals being discharged from community-based Acute Treatment Services (ATS) for Substance Abuse, or can be used by individuals, including pregnant women, who need outpatient services, but who also need more structured treatment for substance abuse.

SOAP provides multidisciplinary treatment to address the subacute needs of Members with addiction and/or co-occurring disorders, while allowing them to maintain employment and participation in the community. SOAP services can only be provided in DPH-licensed, freestanding facilities skilled in addiction recovery treatment, outpatient departments in acute-care hospitals, or outpatient agencies of health care professionals.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, continued stay, exclusion and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R] :

Level I: Outpatient Treatment

OUTPATIENT DAY SERVICES

Structured Outpatient Addiction Program with Motivational Interviewing (SOAP with MI)

Structured Outpatient Addiction Program with Motivational Interviewing (SOAP with MI) shall mean short-term, clinically intensive, structured day and/or evening substance abuse services. These programs shall incorporate the evidence-based practice of motivational interviewing into clinical programming to promote individualized treatment planning. These programs can be used as a transition service in the continuum of care for those individuals being discharged from community-based Acute Treatment Services (ATS) for Substance Abuse, or can be used by individuals, including pregnant women, who need outpatient services, but who also need more structured treatment for substance abuse.

SOAP with MI services can only be provided in DPH-licensed, freestanding facilities skilled in addiction recovery treatment, outpatient departments in acute-care hospitals, or outpatient agencies of health care professionals.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, continued stay, exclusion and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level II.1: Intensive Outpatient

OUTPATIENT DAY SERVICES

Enhanced Structured Outpatient Addiction Program (SOAP)

Enhanced Structured Outpatient Addiction Program (SOAP) shall mean short-term, clinically intensive, structured day and/or evening substance abuse services. These programs can be used as a transition service in the continuum of care for those being discharged from community-based acute substance abuse treatment, or can be used by Members, including pregnant women, who need outpatient services, but who also need more structured treatment for substance abuse.

Enhanced SOAPs provide multidisciplinary treatment to address the subacute needs of Members with addiction and/or co-occurring disorders while allowing them to maintain participation in the community, continue to work, and be part of family life. Enhanced SOAP is provided over a consecutive period, with continued stay based on medical necessity criteria. Enhanced SOAP services can only be provided in DPH-licensed, freestanding facilities skilled in addiction recovery treatment, outpatient departments in acute-care hospitals, or outpatient agencies of health care professionals.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, exclusion, continued stay, and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level II.5: Partial Hospitalization

DIVERSIONARY SERVICES

Enhanced Structured Outpatient Addiction Program (SOAP) For Adolescents

Enhanced SOAP for Adolescents shall mean short-term, clinically intensive, structured day and/or evening substance abuse services. These programs can be used as a transition service in the continuum of care for those adolescents being discharged from community-based Acute Treatment Services (ATS) for Substance Abuse, or can be used by Members, including pregnant adolescents, who need outpatient services, but who also need more structured treatment for substance abuse.

Enhanced SOAPs provide multidisciplinary treatment to address the sub-acute needs of adolescent Members with addiction and/or co-occurring disorders, while allowing them to maintain participation in the community, continue to work or attend school, and be part of family life. Enhanced SOAP is provided over a consecutive period, with continued stay based on medical necessity criteria. Enhanced SOAP services can only be provided in DPH-licensed, freestanding facilities skilled in addiction recovery treatment, outpatient departments in acute-care hospitals, or outpatient agencies of health care professionals.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, continued stay, exclusion and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Adolescent Patient Placement Criteria for Level II.5: Partial Hospitalization

OUTPATIENT SERVICES

Outpatient Services (Adults, Adolescents, and Children)

Outpatient Services are those behavioral health services that are rendered in an ambulatory care setting, such as an office, clinic environment, a Member's home, or other locations appropriate to the provision of service for psychotherapy or counseling. Services focus on the restoration, enhancement, and/or maintenance of a Member's level of functioning and the alleviation of symptoms that significantly interfere with functioning in at least one area of the Member's life (e.g., familial, social, occupational, educational). Active family/guardian /natural supports involvement is important unless contraindicated. The goals, frequency, and length of treatment will vary according to the needs of the Member and the response to treatment. A clear treatment focus, measurable outcomes, and a discharge plan (including the identification of realistic discharge criteria) will be developed as part of the initial assessment and treatment-planning process and will be evaluated and revised as necessary.

Outpatient services that emphasize time-effective episodes of care will likely be sufficient for most Members seeking outpatient treatment, including those with more serious and persistent behavioral health conditions. Some Members, however, may require specialty outpatient services, pharmacotherapy, and /or ongoing, intermittent contact with a licensed mental health professional (e.g., once or twice per month) to maintain the individual's optimal level of functioning, to ameliorate significant and debilitating symptoms, and to prevent the need for more intensive levels of care.

All of the following medical necessity criteria for general Outpatient Services apply to:

Outpatient Services Home Based and Non-Facility Based

Outpatient Services School Based.

Criteria

Criteria	
Admission Criteria	<p><i>All of the following criteria are necessary for admission:</i></p> <ol style="list-style-type: none"> 1. The Member demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention. <p style="text-align: center;">OR</p> <p>The Member has a chronic affective illness, schizophrenia, or a refractory behavioral disorder, which by history, has required hospitalization;</p> <ol style="list-style-type: none"> 2. There are significant symptoms that interfere with the Member's ability to function in at least one life area; 3. There is an expectation that the Member has the capacity to make significant progress toward treatment goals, or treatment is necessary to maintain the current level of functioning; and 4. Unless specifically contraindicated, the parents/guardians of children and adolescents are involved and cooperative with family evaluation and appropriate family treatment
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>

<p>Exclusion Criteria</p>	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member has medical conditions or impairments that would prevent beneficial utilization of services; 2. The primary problem is not psychiatric. It is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration; 3. The treatment plan is designed to address goals other than the treatment of active symptoms of DSM-IV-TR diagnosis (e.g., self-actualization); 4. Medication Management level of outpatient care is sufficient to stabilize or maintain the individual's functioning once an episode of active psychotherapy has been completed, or it is unlikely that psychotherapy would be of benefit given the individual's diagnosis, history, or previous response to treatment; or 5. Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in resuming prior level of roles and responsibility.
<p>Continuing Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member's condition continues to meet admission criteria at this level of care; 2. The Member's condition may require more intensive levels of care intermittently, but the Member continues to require ongoing outpatient services for stability in the community and progress towards treatment goals; 3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of an Axis I or Axis II disorder, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are: <ol style="list-style-type: none"> a. permanent cognitive dysfunction without acute Axis I or II diagnosis b. medical illness requiring treatment in a medical setting c. impairment with no reasonable expectation of progress toward treatment goals at this level of care d. chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning 4. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the discharge plan; 5. Treatment planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, attainable goals and objectives stated. Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been implemented and updated with consideration of all applicable and appropriate treatment modalities; 6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice. Expected benefit from all relevant modalities is documented; 7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.

	<p style="text-align: center;">OR</p> <p>Progress toward stabilization of functioning is documented.</p> <p style="text-align: center;">OR</p> <p>Continued outpatient services are expected to prevent the need for more intensive levels of care;</p> <ol style="list-style-type: none"> 8. The Member is actively participating in the plan of care and treatment to the extent possible consistent with the Member’s condition; 9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them; 10. When medically necessary, appropriate psychopharmacological intervention has been evaluated and/or prescribed; 11. There is documented active discharge planning from the beginning of treatment; and 12. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.
<p>Discharge Criteria</p>	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member no longer meets admission criteria or meets criteria for a less or more intensive level of care; 2. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less intensive level of care. 3. The Member, parent, and/or legal guardian is not engaged in treatment or is not following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member, parent, and/or guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 4. Consent for treatment is withdrawn. In addition, it has been determined that the Member, parent, and/or legal guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; 5. The Member and/or family are not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care or treatment approach, nor is it required to maintain the current level of functioning; or 6. It is reasonably predicted that continuing stabilization can occur with discharge from care and/or Medication Management level of care only and community support.

OUTPATIENT SERVICES

Medication Management (Adult/Child/Adolescent)

Medication management is the level of outpatient treatment where the primary service rendered is by a qualified prescribing provider who evaluates the Member's need for psychotropic medications, the provision of a prescription, ongoing medical monitoring, and coordination of this care with other mental health and substance abuse treatment and medical care. Interactive psychotherapy is not being rendered at this time by the prescribing provider, but may be provided by another clinician.

Criteria

Admission Criteria	<p><i>Both of the following criteria are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. All of the admission criteria for Outpatient Services; and 2. There is a need for prescribing and monitoring psychotropic medications.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Either of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. There is another prescribing provider already certified and currently providing duplicative medication management services; or 2. There is a need for the prescribing provider also to provide interactive psychotherapy. (In this instance, one of the other levels of outpatient treatment would be applicable.)
Continuing Stay Criteria	<p><i>All of the following criteria (1-4) are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. All of the continuing stay criteria for Outpatient Services; 2. For an adult Member, unless contraindicated, family and/or guardian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them; 3. For a child/adolescent Member, parents and/or guardian must be actively involved in the treatment; and 4. Children who are 4 years old and under and their parents and/or guardian are concurrently engaged in other mental health treatment.
Discharge Criteria	<p><i>Any of the following criteria (1-3) is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member no longer requires psychotropic medication; 2. The Member, parents, and/or legal guardian is not engaged in pharmacotherapy. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member, parent, and/or legal guardian has the capacity to make an informed decision, and the

	<p>Member does not meet the criteria for a more intensive level of care; or</p> <p>3. Consent for pharmacotherapy is withdrawn. In addition, it has been determined that the Member, parents, and/or legal guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care.</p>
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OUTPATIENT SERVICES

Complex Medication Management

Complex medication management and monitoring is a more intensive level of treatment that must meet all criteria for routine medication management as above, and the Member's presentation requires additional time with the provider due to any of the following circumstances.

This is an addendum to the general Medication Management services. All Medication Management services criteria for admission, exclusion, continued stay and discharge apply to this level of care as well as the specific criteria listed below.

Additional Criteria	<i>At least one of the following criteria (1-3) must be met:</i>
	<ol style="list-style-type: none"> 1. The Member presents with complex communication ability such as: <ol style="list-style-type: none"> a. requiring a translator; b. a child/adolescent who requires an interview of family/guardian/ caregivers as well as the child/adolescent; c. a Member with mental retardation or other developmental disability who is unable to participate fully in the interview and requires an interview of parents/guardian/caregivers; or d. a Member and/or family/guardian/caregivers requiring unusually extensive teaching. 2. The Member has a complex medical/psychiatric presentation as evidenced by: <ol style="list-style-type: none"> a. being on Clozaril; b. being prescribed four or more medications; c. having a complex medical situation requiring frequent laboratory monitoring and/or coordination with medical caregivers; d. being at risk of medical decompensation; or e. a dually diagnosed Member requiring monitoring of substance abuse as well as medication. 3. The Member presents with an urgent or emergent situation such as: <ol style="list-style-type: none"> a. less than six weeks post-discharge from an intensive level of care (i.e., inpatient, PHP, CBAT); b. prescribing for outpatient detoxification outside of a formal detoxification program; c. a decompensated state that requires frequent visits and medication changes to prevent admission to a more intensive level of care; or d. current presentation of possible suicidality, violence, or dangerousness toward others.

OUTPATIENT SERVICES

Psychiatric Consultation on an Inpatient Medical Unit

Consultation-liaison (C-L) psychiatry is the subspecialty of psychiatry concerned with medically and surgically ill patients. Consults may be obtained on Members hospitalized on medical/surgical units. This service does not apply to Members presenting to emergency departments (EDs). In general, the aims of psychiatric consultation on medical/surgical units are: 1) to ensure the safety and stability of Members within the medical environment; 2) to collect sufficient history and medical data from appropriate sources to assess the Member and formulate the problem; 3) to conduct a mental status examination; 4) to establish a differential diagnosis; and 5) to initiate a treatment plan.

Whenever possible, the consultant is a liaison psychiatrist working as part of a ward-based multidisciplinary team and is familiar with the routines of the medical/surgical environment. The use of outside consultants, unknown to hospital physicians and unfamiliar with the particular hospital system, is to be discouraged.

Criteria

Admission Criteria	<p><i>The following criterion is necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member is an inpatient on a medical/surgical unit. <p><i>One of the following criteria (2-7) is also necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 2. The Member has a suspected psychiatric or behavioral disorder, a significant psychiatric history, or current or recent use of psychotropic medications; 3. The Member has a high risk for psychiatric problems by virtue of serious medical illness (e.g., organ transplantation); 4. The Member displays acute agitation as a result of psychosis, intoxication, withdrawal, dementia, delirium, or other etiologies (e.g., toxic metabolic disturbances, cardiopulmonary, endocrine, neurologic disorders); 5. The Member expresses suicidal or homicidal ideation or a wish to die, including a request for hastened death, physician-assisted suicide, or euthanasia; 6. The Member's care involves a medicolegal situation (e.g., where there is a question of a patient's capacity to consent to or refuse medical or surgical treatment); or 7. The Member has a known or suspected substance use disorder.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>The following criterion is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The Member can be safely maintained and effectively treated without psychiatric consultation.

Continued Stay Criteria	<i>One of the following criteria (1-2) is necessary for continuing consultation:</i> <ol style="list-style-type: none"><li data-bbox="529 268 1369 359">1. There is a need for ongoing data collection, systems interventions, psychopharmacological monitoring, prevention of behavioral or psychiatric relapse, or increased compliance with treatment recommendations; or<li data-bbox="529 386 1393 476">2. The Member needs restraints or is on constant observation, remains psychotic, agitated, potentially violent, psychiatrically unstable or suicidal, or a delirium has not resolved.
Discharge Criteria	The Member no longer requires psychiatric consultation services.

OUTPATIENT SERVICES

Assessment for Safe and Appropriate Placement (ASAP)

Assessment for Safe and Appropriate Placement does not require medical necessity criteria as the need for this service is determined by the Department of Social Services.

SUBSTANCE ABUSE OUTPATIENT SERVICES

Acupuncture Treatment

Acupuncture treatment shall mean the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.

Criteria

For admission, exclusion, continued stay, and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level 1 – Outpatient Treatment

SUBSTANCE ABUSE OUTPATIENT SERVICES

Opioid Replacement Therapy

Opioid replacement therapy shall mean medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA)-approved medications to opiate-addicted individuals, in conformance with FDA regulations. This service combines medical and pharmacological interventions with counseling, educational, and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.

Opioid replacement therapy is provided under a defined set of policies and procedures, including admission, continued stay, and discharge criteria stipulated by Massachusetts state regulations and the federal regulations of FDA 21 CFR Part 291.

Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made, and documented, to involve them.

Criteria

For admission, exclusion, continued stay, and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level 1: Opioid Maintenance Therapy

SUBSTANCE ABUSE OUTPATIENT SERVICES

Ambulatory Detoxification

Ambulatory detoxification is provided in an outpatient clinical setting, under the direction of a physician, and is designed to stabilize the medical condition of an individual experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory detoxification is indicated when the Member experiences physiological dysfunction during withdrawal, but neither life nor significant bodily functions are threatened. The Member may or may not require medication, and 24-hour nursing is not required. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment. Ambulatory detoxification services can be provided in an intensive outpatient program.

Criteria

For admission, exclusion, continued stay, and discharge criteria, see *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition – Revised*. [ASAM PPC-2R]

Level II: Ambulatory Detoxification with Extended On-Site Monitoring

OTHER OUTPATIENT SERVICES

ElectroConvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The Member receiving treatment is placed under general anesthesia, and muscle relaxants are given to prevent body spasms. The ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). Unilateral placement is usually to the non-dominant side of the brain, with the aim of reducing cognitive side effects. The amount of current to induce a seizure (the seizure threshold) can vary up to 40 fold among individuals. ECT may cause short- or long-term memory impairment of past events (retrograde amnesia) and current events (anterograde amnesia). The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is most commonly performed at a schedule of three (3) times per week. Maintenance ECT is most commonly administered at one- to three-week intervals.

The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific patient. This analysis considers the diagnosis of the patient and the severity of the presenting illness, the patient's treatment history, the anticipated speed of action and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT.

Criteria

Admission Criteria	<p><i>The following criterion is necessary for admission:</i></p> <ol style="list-style-type: none"> The Member has been evaluated by a licensed psychiatrist and demonstrates symptomatology consistent with a DSM-IV-TR Axis I diagnosis of major depression, bipolar disorder, mania, schizophrenia, or related psychotic disorder, which requires, and can reasonably be expected to respond to, ECT. <p><i>In addition, one of the following criteria (2-4) must be present:</i></p> <ol style="list-style-type: none"> The Member has the need for a rapid or higher probability of response than that offered by other somatic treatments because of severe medical illness or significant risk to harm themselves or others; The Member has failed to respond to reasonable trials of pharmacotherapy; or The Member is at risk of relapse or reoccurrence of a major mental illness that was successfully treated with ECT in the past.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>One of the following criteria (1-2) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> The Member can be safely maintained and effectively treated with a less intrusive therapy; or Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific Member from this level of care. Such

	<p>conditions include but are not limited to:</p> <ul style="list-style-type: none"> a. unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease; b. aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure; c. increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions; d. recent cerebral infarction; e. pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia; and f. anesthetic risk rated as ASA level 4 or 5.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria (1-10) are necessary for continuing treatment:</i></p> <ol style="list-style-type: none"> 1. Treatment planning is individualized and appropriate to the Member's changing condition with realistic and specific goals and objectives stated. This process should actively involve family, guardian, and/or other natural support systems unless contraindicated; 2. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice; 3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved; or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident; 4. Care is rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the discharge plan. The provider documents that there is careful monitoring of mood, psychosis, cognitive factors, and physical symptoms between treatments; 5. The total number of treatments administered should be a function of both the degree and rate of clinical improvement and the severity of adverse side effects. The typical course of treatment is between 6-12 sessions. In the absence of significant clinical improvement after 6-10 sessions, the indication for continued ECT should be reassessed. Partial response is necessary to go beyond 10 sessions; 6. The Member is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition; 7. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as the treatment plan requires or there are active efforts being made and documented to involve them. 8. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; 9. There is documented active discharge planning from the beginning of

	<p>treatment; and</p> <p>10. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.</p>
<p>Discharge Criteria</p>	<p><i>Any of the following criteria (1-7) is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed. A follow-up aftercare appointment is arranged for a timeframe consistent with the Member's condition and applicable MBPH standards; 2. The Member, family, and/or legal guardian is competent but not engaged in treatment or in following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues; 3. Consent for treatment is withdrawn and, either it has been determined that involuntary ECT treatment is inappropriate, or the court has denied a request to issue an order for involuntary ECT treatment; 4. Support systems that allow the Member to receive ECT in a less restrictive treatment environment have been secured; 5. The Member is not making progress toward treatment goals, and there is no reasonable expectation of progress, nor is ECT required to maintain the current level of functioning; or 6. The Member's physical condition necessitates discontinuation of ECT or transfer to a medical facility.

OTHER OUTPATIENT SERVICES

Psychological/Neuropsychological Testing (Child/Adolescent)

Psychological testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a Member's psychological or cognitive functioning. Psychological tests are used to assess a Member's cognitive, emotional, behavioral, and intrapsychic functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing. The psychologist's aim is to obtain data from standardized, valid and reliable instruments that:

- Lead to an accurate diagnosis;
- Allow for hypotheses to be generated about the Member's problems and difficulties in functioning; and
- Point to effective treatment strategies.

There are four categories of psychological and/or neuropsychological testing that MBHP is contracted to authorize:

1. Psychological Testing (General)
2. Medically Driven Psychological Testing
3. Developmentally Driven Psychological Testing
4. Chapter 766 Related Psychological Testing

These distinct categories of testing can include standard psychological as well as neuropsychological assessment procedures. The categories are differentiated from each other by the referral source and referral question(s) rather than by the assessment procedures employed. Each of the four categories has specific and unique testing certification criteria as outlined below.

Unless otherwise indicated, MBHP's use of the term, "psychological testing/assessment," will refer to both psychological and/or neuropsychological testing/assessment procedures. Likewise, unless otherwise specified, the term "psychologist" will refer to both psychologists and neuropsychologists interchangeably.

Definitions:

1. Psychological Testing (General) - includes psychological and/or neuropsychological procedures

Psychological Testing (General) is a distinct category of testing that is defined by a referral driven by mental health and/or substance use disorder treatment/assessment issues. A medical co-morbidity may exist, but the primary purpose of the assessment is related to mental health and/or substance use disorder treatment/assessment.

2. Medically Driven Psychological Testing

Medically Driven Psychological Testing is a distinct category of testing that is defined by a referral driven by specific, medical (non-psychiatric) treatment/assessment issues. A mental health and/or substance abuse co-morbidity may exist, but the primary purpose of the assessment is related to a medical (non-psychiatric) treatment/assessment issue.

In an outpatient setting, only a primary care physician (or his or her agent) may make a referral for Medically Driven Psychological Testing. In a medical inpatient setting, only the attending physician (or his or her agent) may make a referral for Medically Driven Psychological Testing.

3. Developmentally Driven Psychological Testing

General clinical, medical, school, or early intervention providers determine developmental assessment needs.

4. Chapter 766 Related Psychological Testing

Chapter 766 referrals are initiated by the home school special education department. The purpose is completion of the psychological testing portion of initial and three-year special education re-evaluations that lead to an individualized education plan.

The diagnosis of ADHD can, in most instances, be made on the basis of DSM-IV-TR criteria alone, and such diagnosis does not necessarily require psychological testing. The administration of a *fixed*, standard battery of tests is not considered medically necessary; thus, the process *approach* of selecting specific tests, which are directly responsive to the referral questions and presenting problems, is generally endorsed by MBHP. (A *fixed*, standard battery is one that is either given to all patients regardless of diagnostic question, or a battery of tests given, for example, to all new patients.)

Criteria	
Admission Criteria	<p><i>Either 1 or 2 are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. Testing is needed for a differential diagnosis of a covered mental health condition, which is not clear from a traditional assessment (i.e., clinical interview, brief rating scales), and diagnostic clarity is needed for effective psychotherapy or psychopharmacotherapy treatment planning; or 2. The individual has not responded to standard treatment with no clear explanation of treatment failure, and testing will have a timely effect on the individual treatment plan.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following criteria (1-20) is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. Testing was administered within the last year, and there is no strong evidence that the patient's situation or functioning is significantly different; 2. Testing is primarily for educational purposes with the exception of Chapter 766; 3. Testing is requested within 30 days of active substance abuse; 4. Testing is primarily to guide the need for, or titration of, medication; 5. Testing is primarily for legal or forensic purposes; 6. Testing is primarily for medical guidance, cognitive rehabilitation, or vocational guidance, as opposed to the Admission Criteria purposes stated above; 7. Testing request appears more routine than medically necessary. <i>Psychological testing should not be routinely administered</i> as an approach to evaluation or based primarily on a requirement of the facility. It should be guided by individual clinical circumstances; 8. Specialized training by provider is not documented; 9. Administration, scoring, and/or reporting of projective testing is performed by someone other than a fully licensed psychologist, or other mental health professional whose scope of training and licensure includes such testing; 10. Interpretation and supervision of neuropsychological testing (excluding the administration of tests) is performed by someone other than a licensed psychologist with a specialty in neuropsychology;

	<ol style="list-style-type: none"> 11. Measures proposed have no standardized norms or documented validity; 12. The time requested for a test/test battery falls outside MBHP's established time parameters; 13. Extended testing for ADHD has been requested prior to provision of a thorough evaluation, which has included a developmental history of symptoms and administration of rating scales; 14. Symptoms of acute psychosis, confusion, disorientation, etc, interfering with proposed testing validity are present; 15. Testing is primarily for vocational guidance; 16. Testing is for a parenting evaluation; 17. Testing is for a disability determination; 18. The request for testing is not an agreed-upon component of a coordinated treatment plan; 19. Standard psychodiagnostic evaluation may answer referral question; or 20. Testing is included in the per diem rate for a facility or program.
Continued Stay Criteria	<i>Does not apply.</i>
Discharge Criteria	<i>Does not apply.</i>

EMERGENCY SERVICES

Emergency Services Program (ESP) Encounter (Adult/Child/Adolescent)

The Emergency Services Program (ESP) provides on-site and mobile crisis intervention assessment and treatment 24 hours per day, seven days per week to individuals in an active state of crisis. The purpose of the ESP is to respond rapidly, assess effectively, and provide early intervention to help individuals and their families who are in crisis, ensuring their safety and entry into the continuum of care at the appropriate level. This would include, as clinically indicated, direct provision of crisis assessment, including collateral contacts, coordination of care with other behavioral health providers, short-term crisis counseling, and medication evaluation and prescription. The ESP facilitates all necessary acute medical evaluation and uses this information to inform the crisis assessment and planning. The ESP also identifies services and alternatives that will minimize distress and aid in crisis stabilization. Referrals and coordination of services are provided to link individuals and their families with other service providers and community supports that can assist with maintaining maximum functioning in the least restrictive environment. This service may be provided on-site in an Emergency Services Program, in medical emergency departments, or in community settings in response to requests by police, providers, community-based agencies, family members, guardians, protective service workers, or the individual in crisis.

Crisis intervention requires flexibility in the duration of the initial intervention, the person's participation in the treatment, and the number and type of follow-up services. It is crucial that the individual and his/her family or other primary caretakers/guardians and natural support systems participate in the crisis intervention process whenever possible.

Criteria

Admission Criteria	<p><i>Both of the following criteria (1-2) are necessary for admission to this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual must be in an active state of crisis; and 2. The intervention must be reasonably expected to improve/stabilize the individual's condition and resolve the crisis safely in the community or to determine that a more intense treatment is immediately necessary and arrange for such treatment disposition at the appropriate level of care. <p><i>In addition to the above, at least one of the following (3-4) must be present:</i></p> <ol style="list-style-type: none"> 3. The individual demonstrates and/or collateral contact(s) report suicidal/assaultive/ destructive ideas, threats, plans, or attempts that represent risk to self or others as evidenced by degree of intent, lethality of plan, means, hopelessness, or impulsivity; or 4. The individual demonstrates and/or collateral contact(s) report an incapacitating or debilitating disturbance in mood/thought/behavior that is disruptive to interpersonal, familial, occupational, and/or educational functioning to the extent that immediate intervention is required.
Psychosocial, Occupational, and Cultural and Linguistic Factors	<p><i>These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.</i></p>
Exclusion Criteria	<p><i>Does not apply.</i></p>

Continued Stay Criteria	<i>Does not apply.</i>
Discharge Criteria	<p><i>Any of the following criteria (1-3) is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual is released or transferred to an appropriate treatment setting based on crisis intervention, evaluation, and resolution; 2. A plan of aftercare follow-up is in place and is expected to reasonably continue to provide services and prevent exacerbation of the crisis; or 3. Consent for treatment is withdrawn, and it has been determined that the individual, parents, and/or guardian has the capacity to make an informed decision. In addition, the individual does not meet the criteria for a more intensive level of care; involuntary inpatient treatment is inappropriate; or the court has denied involuntary inpatient treatment.