California Medical Necessity Criteria

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College Health IPA (CHIPA) Medical Necessity/ Level of Care Criteria

College Health IPA (CHIPA) uses its Medical Necessity Criteria (MNC) as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. CHIPA's MNC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular level of care. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

Medically Necessary Services are defined as those that are:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity.
2. Expected to improve an individual's condition or level of functioning.
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
4. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
6. Not primarily intended for the convenience of the recipient, caretaker, or provider.
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
8. Not a substitute for non-treatment services addressing environmental factors
9. Reasonable and necessary to protect life, prevent illness or disability, or to ease pain through the diagnosis or treatment of disease, illness or injury.
10. Services needed to assist members in achieving age-appropriate growth and development, and attain, maintain, or regain functional capacity.

*In order to comply with Federal and State Parity and in accordance with the Health Plan's definition of Medical Necessity, CHIPA applies Health Plans definition of MN that is outlined in UM policy 205 addendum.

CHIPA never requires the attempt of a less intensive treatment as a criterion to authorize any service.

The following Medical Necessity Criteria are intended to be used by College Health IPA (CHIPA) Clinical Utilization Management staff, Peer Advisors and Providers in determining the appropriate level of care for individuals with mental health. Unless mandated by regulation or contract, CHIPA utilizes the American Society of Addiction Medicine (ASAM) criteria for the management of all substance use services.

In addition, **For California Medi-Cal services**, Medical Necessity is defined as reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as under Title 22 California Code of Regulations (CCR) Section 51303. Where there is an overlap between Medicare and Medi-Cal benefits (e.g., durable medical equipment services), the CHIPA will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards.

For Medicare Plans: Medicare (CMS) Guidelines are applied first, followed by State and National Coverage Determinations and then CHIPA LOCC. (Medicare Clinical Review Process Hierarchy is available in the P&P on Application of Level of Clinical Criteria for Medicare)

In addition to meeting Level of Care Criteria; services must be included in the member's benefit to be considered for coverage.

Overview of the Medical Necessity Criteria *(Note: Hyperlinks are enabled on this page.)*

SECTION I: INPATIENT SERVICES
A. NMNC 1.101.02 Inpatient Psychiatric Services
B. NMNC 1.102.02 Observation Beds

SECTION II: RESIDENTIAL TREATMENT SERVICES
A. NMNC 2.202.03 Residential Treatment Services

SECTION III: STRUCTURED DAY TREATMENT SERVICES
A. NMNC 3.301.02 Partial Hospitalization Program
B. NMNC 3.302.02 Intensive Outpatient Treatment

SECTION IV: EMERGENCY/ CRISIS SERVICES
A. NMNC 2.201.02 Crisis Stabilization

SECTION V: OUTPATIENT SERVICES
A. NMNC 5.501.02 Outpatient Professional Services
B. NMNC 5.502.02 Psychological and Neuropsychological Testing
C. NMNC 6.604.03 Applied Behavioral Analysis (ABA)

Section VI: OTHER BEHAVIORAL HEALTH SERVICES
A. NMNC 6.601.02 Electro-Convulsive Therapy
B. NMNC 6.602.02 Repetitive Transcranial Magnetic Stimulation
C. NMNC 6.605.01 Substance Use Laboratory Testing for Drug and Alcohol Use

SECTION I: INPATIENT SERVICES

A. NMNC 1.101.02 Inpatient Psychiatric Services

Acute Inpatient Psychiatric Services are the most intensive level of psychiatric treatment used to stabilize individuals with an acute, worsening, destabilizing, or sudden onset psychiatric condition with a short and severe duration. A structured treatment milieu and 24-hour medical and skilled nursing care, daily medical evaluation and management (including a documented daily visit with an attending licensed prescribing provider), and structured milieu treatment are required for inpatient treatment. Treatment may include physical and mechanical restraints, isolation, and locked units.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Must have all criteria #1-4 and either 5 or 6; criteria #7 and #8 as applicable; for Eating Disorders #9-12 must also be met: 1. Symptoms consistent with a DSM or corresponding ICD diagnosis. 2. Member's psychiatric condition requires 24-hour medical/psychiatric and nursing services and of such intensity that needed services can only be provided in an acute psychiatric hospital. 3. Inpatient psychiatric services are expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed. 4. Symptoms do not result from a medical condition that would be more appropriately treated on a medical/surgical unit.	**Criteria #1 - 10 must be met; For Eating Disorders, criterion #11 or 12 must be met:** 1. Member continues to meet admission criteria. 2. Another less restrictive Level of Care would not be adequate to administer care. 3. Member is experiencing symptoms of such intensity that if discharged, s/he would likely require rapid re- hospitalization. 4. Treatment is still necessary to reduce symptoms and improve functioning so that the member may be treated in a less restrictive Level of Care. 5. There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment continuing in a less restrictive Level of Care. 6. Medication assessment has been completed when appropriate and	**Any one of the following: Criteria #1, 2, 3, or 4; criteria # 5 - 7 are recommended, but optional. For Eating Disorders, criteria #8 - 10 must be met:** 1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment *and/or* member does not meet criteria for involuntary or mandated treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met.

5. One of the following must also be present: a. Danger to self: i. A serious suicide attempt by degree of lethality and intentionality, suicidal ideation with plan and means available and/or history of prior serious suicide attempt; ii. Suicidal ideation accompanied by severely depressed mood, significant losses, and/or continued intent to harm self; iii. Command hallucinations or persecutory delusions directing self-harm; iv. Loss of impulse control resulting in life threatening behavior or danger to self; v. Significant weight loss within the past three months; vi. Self-mutilation that could lead to permanent disability; vii. Uncontrolled risk taking behaviors b. Danger to others: i. Homicidal ideation and/or indication of actual or potential danger to others; ii. Command hallucinations or persecutory delusions directing harm or potential violence to others; iii. Indication of danger to property evidenced by credible threats of destructive acts;	medication trials have been initiated or ruled out. Treatment plan has been updated to address non-adherence. 7. The member is actively participating in plan of care and treatment to the extent possible consistent with his/her condition. 8. Family/guardian/caregiver is participating in treatment as appropriate. 9. There is documentation of coordination of treatment with state or other community agencies, if involved. 10. Coordination of care and active discharge planning are ongoing, beginning at admission, with goal of transitioning the member to a less intensive Level of Care. *(See below for Eating Disorder Criteria)*	6. Member's support system is aware and in agreement with the aftercare treatment plan. 7. Member's physical condition necessitates transfer to a medical facility. *(See below for Eating Disorder Criteria)*

iv. Documented or recent history of violent, dangerous, and destructive acts 6. Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning. 7. Evidence of severe disorders of cognition, memory, or judgment are not associated with a primary diagnosis of dementia or other cognitive disorder (e.g. acute psychotic symptoms). 8. Severe comorbid substance use disorder is present and must be controlled (e.g. abstinence necessary) to achieve stabilization of primary psychiatric disorder.		
For Eating Disorders: * Weight alone should not be the sole indicator of admission or discharge. 9. DSM or corresponding ICD diagnosis and symptoms consistent with a primary diagnosis of Eating Disorder. 10. Member has at least one of the following: a. Psychiatric, behavioral, and eating disorder symptoms that are expected to respond to treatment in an Acute Level of Care; b. Symptomatology that is not responsive to treatment in a less intensive Level of Care; c. An adolescent with newly diagnosed anorexia 11. Member requires 24-hour monitoring, which includes: before, after, and during	**For Eating Disorders**: 11. Member has had no appreciable weight gain (<2lbs/wk.). 12. Ongoing medical or refeeding complications.	**For Eating Disorders:** 8. Member has reached at least 85% ideal body weight and has gained enough weight to achieve medical stability (e. g., vital signs, electrolytes, and electrocardiogram are stable). 9. No re-feeding is necessary. 10. All other psychiatric disorders are stable.

meals; evening to monitor behaviors (i.e. restricting, binging/purging, over-exercising, use of laxatives or diuretics). 12. Member exhibits physiological instability requiring 24-hour monitoring **for at least one (1) of the following**: a. Rapid, life-threatening and volitional weight loss not related to a medical illness: generally <80% of IBW (or BMI of 15 or less; b. Electrolyte imbalance (i.e. Potassium <3); c. Physiological liability (i.e. Significant postural hypotension, bradycardia, CHF, cardiac arrhythmia); d. Change in mental status; e. Body temperature below 96.8 degrees; f. Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement; g. Acute gastrointestinal dysfunction (i.e. Esophageal tear secondary to vomiting, mega colon or colonic damage, self-administered enemas); h. Heart rate is less than 40 beats per minute for adults or near 40 beats per minute for children		
Exclusions: Any of the following criteria is sufficient for exclusion from this level of care: 1. The individual can be safely maintained and effectively treated at a less intensive level of care.		

2. Symptoms result from a medical condition which warrants a medical/surgical setting for treatment. 3. The individual exhibits serious and persistent mental illness **and** is not in an acute exacerbation of the illness. 4. The primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.		

B. NMNC 1.102.02 Observation Behavioral Health Service

Observation (OBS) Beds allow time for extended assessment for observation in a secure, medically staffed, psychiatrically monitored setting. The objective of this setting is for prompt evaluation and stabilization services that will likely result in a referral to a less intensive setting, or provides a safe environment to obtain additional information about the member's condition in order to obtain a referral to a more appropriate setting (more or less intensive). This level of care is generally used for a duration of 24 hours or less, though may be extended as required, for a maximum of 72 hours.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. Symptoms consistent with a DSM or corresponding ICD Diagnosis. 2. Indication that the symptoms may stabilize within a 23-72 hour period at which time a less restrictive level of care will be appropriate. 3. One of the following must be present: a. Indication of actual or potential danger to self or others as evidenced by:	**All of the following criteria must be met:** 1. Member continues to meet admission criteria. 2. Another less restrictive level of care would not be adequate to provide needed containment and administer care. 3. Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care.	**Any one of the following: Criteria #1, 2, 3, or 4; Criteria # 5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment *and* member does not meet criteria for involuntary/mandated treatment.

i. Suicidal intent or recent attempt with continued intent; ii. Homicidal ideation; iii. Command hallucinations or delusions; b. Loss of impulse control leading to life-threatening behavior and/or psychiatric symptoms that require immediate stabilization in a structured, psychiatrically monitored setting; c. Substance intoxication with suicidal/homicidal ideation or inability to care for self; d. Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning; 4. Presenting crisis cannot be safely evaluated or managed in a less restrictive setting. 5. Member is willing to participate in treatment voluntarily.	4. There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment continuing in a less restrictive level of care. 5. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6. Family/guardian/caregiver is participating in treatment as clinically indicated, or engagement efforts are underway. 7. Coordination of care and active discharge planning includes goal of transitioning the member to a less intensive level of care or transferring the member to a higher level of care.	3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan.
Exclusions Any of the following criteria are sufficient for exclusion from this level of care: 1. The individual 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 or corresponding ICD diagnosis amenable to acute treatment.		

3. Presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care. 4. The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting the criteria for this level of care. 5. Admission is being used as an alternative to incarceration.		

SECTION II: RESIDENTIAL TREATMENT SERVICES (24 HOURS DIVERSIONARY SERVICES)

A. NMNC 2.202.03 Residential Treatment Services (RTS)

Residential Treatment Services also known as a Residential Treatment Center (RTC) are 24-hours, 7 days a week facility-based programs that provide individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming, such as group, CBT, DBT and motivational interviewing, within a milieu with a high degree of supervision and structure and is intended for members who does not need the high level of physical security and frequency of psychiatric or medical intervention that are available on an inpatient unit. In addition, the program provides individualized therapeutic treatment. RTS is not an equivalent for long-term hospital care; rather its design is to maintain the member in the least restrictive environment to allow for stabilization and integration. Consultations and psychological testing, as well as routine medical care, are included in the per diem rate. RTSs serve members who have sufficient potential to respond to active treatment, need a protected and structured environment and for whom outpatient, partial hospitalization or acute hospital inpatient treatments are not appropriate. Realistic discharge goals should be set upon admission, and full participation in treatment by the member and his or her family members, as well as community-based treatment providers is expected when appropriate. Physician evaluation and re-evaluations are based on each individual member's clinical needs.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1 – 9 must be met for all; Criteria 10 when applicable. For Eating Disorders, criteria # –11-15 must also be met:	**Criteria # 1 – 11 must be met for all; For Eating Disorders criteria # 10 and 11 must be met:**	**Criteria # 1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional;**

1. DSM or corresponding ICD diagnosis and must have a mood, thought, or behavior disorder which requires, and can reasonably be expected to respond to therapeutic interventions. 2. The member is experiencing emotional or behavioral problems in the home, 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 setting. 3. The member may not be appropriate for a different level of care as evidenced by a series of increasingly dangerous behaviors which present significant risk 4. Member has sufficient cognitive capacity to respond to active, intensive and time-limited psychological treatment and intervention. 5. Severe deficit in ability to perform self-care activity is present (eg, self-neglect with inability to provide for self at a lower level of care). 6. Member has only poor to fair community supports sufficient to maintain him/her within the community with treatment at a lower level of care. 7. Member requires a time-limited period for stabilization and community re-integration. 8. When appropriate, family/guardian/ caregiver agree to participate actively in treatment as a condition of admission.	1. Member continues to meet admission criteria; 2. Another less restrictive level of care would not be adequate to provide needed containment and administration of care. 3. Member is experiencing symptoms of such intensity that if discharged, s/he would likely be readmitted; 4. Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care. 5. There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment in a less restrictive level of care; 6. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 7. Member evaluation by physician occurs on at least a weekly basis. 8. Member's progress is monitored regularly and the treatment plan is modified, if the member is not making progress towards a set of clearly defined and measurable goals. 9. Member is engaged in treatement and amenable to goals/interventions set forth by the treatment team. 10. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate or engagement is underway.	**For Eating Disorders, criterion # 7 must be met:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, more or less intensive. 2) Member or parent/guardian withdraws consent for treatment and the member does not meet criteria for involuntary/mandated treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan. *(See below for Eating Disorder Criteria)*

9. Member's behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment. 10. Severe comorbid substance use disorder is present that must be controlled (e.g., abstinence necessary) to achieve stabilization of primary psychiatric disorder. *(See below for Eating Disorder Criteria)*	11. There must be evidence of coordination of care and active discharge planning to: a. Transition the member to a less intensive level of care; b. Operationalize how treatment gains will be transferred to subsequent level of care. *(See below for Eating Disorder Criteria)*	
For Eating Disorders: *** Weight alone should not be the sole criteria for admission or discharge.** 9) Weight stabilization: generally <85% of IBW (or BMI of 15 or less),with no significant co-existing medical conditions (see IP #14) 10) Member is medically stable and does not require IV fluids, tube feedings or daily lab tests. 11) Member has had a recent significant weight loss and cannot be stabilized in a less restrictive level of care. 12) Member needs direct supervision at all meals and may require bathroom supervision for a time period after each meal. 13) The member is unable to control obsessive thoughts or to reduce negative behaviors (e. g., restrictive eating, purging, laxative or diet pill abuse, and/or excessive exercising) in a less restrictive environment.	**For Eating Disorders:** 10) Member continues to need supervision for most if not all meals and/or use of bathroom after meals. 11) Member has had no appreciable weight gain since admission.	**For Eating Disorders** 7) Member has gained weight, is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care.

Exclusions **Any** *of the following criteria is sufficient for exclusion from this level of care:* 1) Member's IBW is < 75% (or BMI of 14 or less) 2) The individual exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care. 3) The individual does not voluntarily consent to admission or treatment. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 5) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 6) The primary problem is social, legal, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as custodial care or as an alternative to incarceration.		

SECTION III: STRUCTURED DAY TREATMENT SERVICES (NON 24 HOUR DIVERSIONARY SERVICES)

A. NMNC 3.301.02 Partial Hospitalization Program

Partial hospitalization programs (PHP) are short-term day programs consisting of intensive, acute, active treatment in a therapeutic milieu equivalent to the intensity of services provided in an inpatient setting. These programs must be available at least 5 days per week, though may also be available 7 days per week. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires psychiatric oversite with at least weekly medication management as well as highly structured treatment. The treatment declines in intensity and frequency as a member establishes community supports and resumes normal daily activities. A partial hospitalization program may be provided in either a hospital-based or community based location. Members at this level of care are often experiencing symptoms of such intensity that they are unable to be safely treated in a less intensive setting, and would otherwise require admission to an inpatient level of care. **Children and adolescents** participating in a partial hospital program must have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on family, community supports, and school, the PHP consults with the caretakers and the child's programs as needed to implement behavior plans, or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1 - 8 must be met; For Eating Disorders, criterion #9 – 10 must also be met: 1. Symptoms consistent with a DSM or corresponding ICD diagnosis. 2. The member manifests a significant or profound impairment in daily functioning due to psychiatric illness. 3. Member has adequate behavioral control and is assessed not to be an immediate danger to self or others requiring 24-hour containment or medical supervision. 4. Member has a community-based network of support and/or parents/caretakers who are able to ensure member's safety outside the treatment hours. 5. Member requires access to a structured treatment program with an on-site multidisciplinary team, including routine	**Criteria # 1 - 7 must be met; For Eating Disorders, criterion # 8 must also be met:** 1. Member continues to meet admission criteria. 2. Another less intensive level of care would not be adequate to administer care. 3. Treatment is still necessary to reduce symptoms and increase functioning so the member may be treated in a less intensive level of care. 4. Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 5. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	**Any one of the following: Criteria 1, 2, 3, or 4; Criteria # 5 and 6 are recommended, but optional; For Eating Disorders, criterion # 7 is also appropriate:** 1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support systems are in agreement with the aftercare treatment plan.

psychiatric interventions for medication management. 6. Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize their condition. 7. The severity of the presenting symptoms is not able to be treated safely or adequately in a less intensive level of care. 8. Member has adequate motivation to recover in the structure of an ambulatory treatment program.	6. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 7. Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive Level of Care. *(See below for Eating Disorder Criteria)*	*(See below for Eating Disorder Criteria)*
For Eating Disorders: • Weight alone should not be the sole criteria for admission or discharge. 9. Member requires admission for Eating Disorder Treatment and requires at least one of the following: a. Weight stabilization: Generally between 80 and 85% of IBW (or BMI of 15-17) with no significant co-existing medical conditions (see IP #14) b. Continued monitoring of corresponding medical symptoms; c. Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning. 10. Any monitoring of member's condition when away from partial hospital program can be provided by family, caregivers, or other available resources.	**For Eating Disorders:** 8. Member has had no appreciable stabilization of weight since admission. 9. Other eating disorder behaviors persist and continue to put the member's medical status in jeopardy.	**For Eating Disorders**: 7. Member has been adherent to the Eating Disorder related protocols, medical status is stable and appropriate, and the member can now be managed in a less intensive level of care.

Exclusions Any of the following criteria are sufficient for exclusion from this level of care: 1. The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required. 2. The individual does not voluntarily consent to admission or treatment or does not meet criteria for involuntary admission to this level of care. 3. The individual has medical conditions or impairments that would prevent beneficial utilization of services. 4. The individual exhibits a serious and persistent mental illness consistent throughout time **and** is not in an acute exacerbation of the mental illness. 5. The individual requires a level of structure and supervision beyond the scope of the program (e.g., considered a high risk for non-compliant behavior and/or elopement). 6. The individual can be safely maintained and effectively treated at a less intensive level of care.		

B. NMNC 3.302.02 Intensive Outpatient Treatment

Intensive outpatient programs (IOP) offer short-term, multidisciplinary, structured day or evening programming that consists of intensive treatment and stabilization within an outpatient therapeutic milieu setting. IOP must be available at least 3 - 5 days per week. Treatment reduces in intensity and frequency as the member establishes community supports and resumes daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long term day treatment. IOPs may be provided by either hospital- based or freestanding outpatient programs to members who experience symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive level of care. These programs also include 24/7 crisis management services, individual, group, and family therapy, and coordination of medication evaluation and management services, as needed. Coordination with collateral contacts and care

management/discharge planning services should also occur regularly as needed in an IOP. For **children and adolescents**, the IOP provides services similar to an acute level of care for those members with a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child's caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria 1-8 must be met: For Eating Disorders criteria 9-10 must be met: 1. Symptoms consistent with a DSM or corresponding ICD diagnosis. 2. Member is determined to have the capacity and willingness to improve or stabilize as a result of treatment at this level. 3. Member has significant impairment in daily functioning due to psychiatric symptoms or comorbid substance use of such intensity that member cannot be managed in routine outpatient or lower level of care. 4. Member is assessed to be at risk of requiring a higher level of care if not engaged in intensive outpatient treatment. 5. There is indication that the member's psychiatric symptoms will improve within a reasonable time period so that the member can transition to outpatient or community based services. 6. Member's living environment offers enough stability to support intensive outpatient treatment. 7. Member's psychiatric/substance use/biomedical condition is sufficiently	**All of the following criteria 1-9 must be met:** 1. Member continues to meet admission criteria. 2. Another less intensive level of care would not be adequate to administer care. 3. Member is experiencing symptoms of such intensity that if discharged, s/he would likely require a more intensive level of care. 4. Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less intensive level of care. 5. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6. Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress towards clearly defined and measurable goals. 7. Family/guardian/caregiver is participating in treatment as appropriate. 8. There is documentation around coordination of treatment with all involved parties including state/community agencies when appropriate.	**Any one of the following: Criteria #1,2,3, or 4; Criteria #5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2. Member or guardian withdraws consent for treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan.

stable to be managed in an intensive outpatient setting. 8. Needed type or frequency of treatment is not available in or is not appropriate for delivery in an office or clinic setting.	9. The provider has documentation supporting discharge planning attempts to transition the member to a less intensive level of care.	
For Eating Disorders: • Weight alone should not be the sole criteria for admission or discharge 9) Member requires admission for Eating Disorder Treatment and requires at least one of the following: a) Weight stabilization: Generally, between 80 and 85% of IBW (or BMI of 15-17 or more) with no significant co- existing medical conditions (see IP #14) b) Continued monitoring of corresponding medical symptoms; c) Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning. 10) Any monitoring of member's condition when away from intensive outpatient program can be provided by family, caregivers, or other available resources.		
Exclusions Any of the following criteria is sufficient for exclusion from this level of care: 1. The individual is a danger to self and others or sufficient impairment exists that a more intensive level of service is required. 2. The individual has medical conditions or impairments that would prevent beneficial		

utilization of services, or is not stabilized on medications. 3. The individual requires a level of structure and supervision beyond the scope of the program. 4. The individual can be safely maintained and effectively treated at a less intensive level of care. 5. The primary problem is social, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration. 6. The main purpose of the admission is to provide structure that may otherwise be achieved via community based or other services to augment vocational, therapeutic or social activities.		

SECTION IV: EMERGENCY/ CRISIS SERVICES

A. NMNC 2.201.02 Crisis Stabilization

Crisis stabilization beds provide short-term psychiatric treatment within a structured, community-based therapeutic setting. Each program provides continuous, 24-hour observation and supervision for members who do not require the clinical intensity of an inpatient psychiatric setting. The goal of this level of care is to provide a comprehensive assessment, stabilize the member in crisis, and restore the member to a level of functioning that would require a less intensive treatment setting, while preventing an unnecessary hospital admission and transition the member back to community-based services, supports and resources. Beds may be located in a hospital or a community-based setting. Immediate and intense involvement of family and community supports for post-discharge follow-up as clinically indicated is ideal for a crisis stabilization setting. Crisis stabilization also assists members to access appropriate community supports.

Admission Criteria	Continued Stay Criteria	Discharge Criteria

All of the following criteria must be met:	All of the following criteria must be met:	Any one of the following: Criteria # 1, 2, 3, or 4
1. Symptoms consistent with a DSM or corresponding ICD diagnosis. 2. Member likely to respond to rapid stabilization. 3. Member is experiencing an exacerbation of psychiatric symptoms or emotional disturbance including all of the following: a. In relation to a situational crisis; b. Duration and exacerbation of symptoms that is expected to be brief and temporary; c. No imminent risk to self or others requiring a higher level of care; d. Requires 24-hour monitoring; e. Cannot be safely treated in a less restrictive setting; 4. Clinical evaluation indicates life-threatening behavior with insufficient information to determine appropriate level of care beyond a short-term crisis stabilization that is expected to significantly improve the member's symptoms. 5. Member (or guardian as appropriate) is willing to participate in treatment voluntarily.	1. The member continues to meet admission criteria. 2. Another less restrictive level of care would not be adequate to provide needed containment and administer care. 3. Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care. 4. There is evidence of progress towards resolution of the symptoms causing a barrier to treatment continuing in a less restrictive level of care. 5. Member progress is monitored regularly and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 6. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 7. Individual/family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 8. Coordination of care and active discharge planning are ongoing, with goal of transitioning the member to a less intensive Level of Care.	1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member is not making progress toward goals, nor is there expectation of any progress. 4. Functional status acceptable as indicated by one (1) or more of the following: • No essential function is significantly impaired • An essential function is impaired, but impairment is manageable at available lower level of care.

Exclusions Any of the following criteria are sufficient for exclusion from this level of care: 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 hospital. 3. The individual does not voluntarily consent to admission or treatment (unless being used as an alternative to an inpatient level of care). 4. The individual can be safely maintained and effectively treated in a less intensive level of care. 5. Request for service is not being pursued to address a primary issue of homelessness or lack of identified disposition. 6. Admission is being used as an alternative to incarceration.		

SECTION V: OUTPATIENT SERVICES

A. CAMNC 5.501.02 Outpatient Professional Services

Outpatient Behavioral Health treatment is an essential component of a comprehensive health care delivery system. Individuals with a major mental illness, chronic and acute medical illnesses, substance use disorders, family problems, and a vast array of personal and interpersonal challenges can be assisted in coping with difficulties through comprehensive outpatient treatment. The goal of outpatient behavioral health treatment is restoration, enhancement, and/or maintenance of a member's level of functioning and the alleviation of symptoms that significantly interfere with functioning. The goals, frequency, and length of treatment will vary according to the needs and symptomatology of the member. Efficiently designed outpatient behavioral health interventions help individuals and families effectively cope with stressful life situations and challenges. Accordingly, best practice includes preparing the member with a plan or process for managing emergencies or symptoms that may escalate between treatment sessions, including after-hours (e.g. availability of on-call service, community crisis intervention services). Telehealth services

are services that can be provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a provider at a remote location (i.e., distant site).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All criteria must be met. For telehealth Services all admission criteria # 9 -12 must be met.: 1. Member demonstrates symptoms consistent with a DSM or corresponding ICD diagnosis, and treatment focus is to stabilize these symptoms. 2. Member must be experiencing at least one (1) of the following: a. A chronic affective illness, schizophrenia, or a refractory behavioral disorder, which by history, has required hospitalization, OR b. Moderate to severe symptomatic distress or impairment in functioning due to psychiatric symptoms in at least one area of functioning (i.e.. self-care, occupational, school, or social function). 3. There is an expectation that the individual: a. Has the capacity to make significant progress towards treatment goals; b. Requires treatment to maintain current level of functioning; c. Has the ability to reasonably respond and participate in therapeutic intervention.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria. 2. Member does not require a more intensive level or care, and no less intensive level of care would be appropriate to meet the member's needs. 3. Evidence suggests that the identified problems are likely to respond to current treatment plan. 4. Member's progress is monitored regularly, and the treatment plan is modified, if member is not making substantial progress toward a set of clearly defined and measurable goals. 5. Treatment planning includes family or other support systems unless not clinically indicated. 6. The treatment plan is tailored to address the individual needs of the member based upon assessment and reassessment throughout treatment informed by objective outcome/measurements (e.g. rating scales) that assess the member's response to treatment. The treatment plan is modified based on member's progress in or response to care. 7. Frequency and intensity of treatment	**Criteria #1 and any one of # 2 - 9 must be met:** 1. The precipitating factors leading to admission have been resolved or ameliorated such that the member no longer needs care. 2. Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others. 3. Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care. 4. Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment). 5. Member is competent and non-participatory in treatment, or the individual's non-participation is of such degree that treatment at this level of care is rendered ineffective or unsafe despite multiple documented attempts to address non-participation issues. 6. Evidence does not suggest that the defined problems are likely to respond to continued outpatient treatment.

d. Would be at risk to regress and require a more intensive level of care 4. The member does not require a more intensive level of structure beyond the scope of non-programmatic outpatient services. 5. Medication management is not sufficient to stabilize or maintain member's current functioning. 6. The member is likely to benefit from and respond to psychotherapy due to diagnosis, history, or previous response to treatment. 7. The member cannot be adequately stabilized in a rehabilitative or community service setting to assist with: health, social, occupational, economic, or educational issues. 8. Treatment is not being sought as an alternative to incarceration. **Additional Telehealth Specific Admission Criteria #9-12:** 1. Treatment is for psychopharmacological evaluation and management as well as psychotherapy. 2. Geography, specialty or linguistic capacity dictates that in-office visits are not within a reasonable distance or not available. 3. The member must have appropriate equipment, access to high speed Wi-Fi Internet and email to ensure connectivity with the distant site provider for home based telehealth services.	contact occurs at a rate that is appropriate to the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal); and a lower frequency of sessions not would be sufficient to meet the member's needs. 8. Evidence exists that member is at current risk of a higher level of care if treatment is discontinued. 9. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner. 10. There is documented active discharge planning from the beginning of treatment.	7. Member is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment approach. 8. Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives. 9. Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for inpatient level of care. 10. It is reasonably predicted that maintaining stabilization can occur with discharge from care and/or Medication Management only and community support.

4. The member must have access to secure room/environment in the home or similar location and efforts shall be made to ensure privacy so clinical discussion cannot be overheard by others for home based telehealth services.		
Exclusions: Any of the following criteria are sufficient for exclusion from this level of care: 1. The individual requires a level of structure and supervision beyond the scope of non-programmatic outpatient services. 2. The individual has medical conditions or impairments that would prevent beneficial utilization of services. 3. The primary problem is social, occupational, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration. 4. Treatment plan is designed to address goals other than the treatment of active symptoms of DSM or corresponding ICD diagnosis (e.g. self-actualization). 5. Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in resuming prior level of roles and responsibility. 6. Treatment is primarily for the purpose of supportive, respite, social, or custodial care.		

Additional California Medi-cal Specific Exclusions #7-8: 7. Evidence suggests that the member can be treated effectively in the primary care setting, with the option of psychiatric consultation. 8. Criteria is met for services with a Mental Health Plan through Title 9, California Code of Regulations, based on diagnosis and severity of impairment related to the diagnosis. a) Member has moderate to severe symptomatic distress or impairment in functioning due to psychiatric symptoms in at least one area of functioning (i.e., self-care, occupational, school, or social function) and referred to Mental Health Plan. b) The member symptoms require a more intensive level of structure/care beyond the scope of non-programmatic outpatient services (i.e., inpatient hospitalization). Member referred to Mental Health Plan. **Additional Telehealth Specific Exclusions #9-13** 9. Member has access to providers within access standard. 10. Member does not have appropriate equipment, internet connectivity and email to support home based telehealth services. Member does not have the intellectual or emotional capacity to access the on-line		

session for home based telehealth services. 11. Member does not have access to a secure private location either at home or a similar location for home based telehealth services. 12. Member has current symptomology or history that make them clinically inappropriate for home based telehealth services, including but not limited to 13. Member is suicidal, homicidal, dissociated or acutely psychotic.		

B. NMNC 5.502.02 Psychological and Neuropsychological Testing

Psychological and neuropsychological testing is the use of standardized assessment tools to gather information relevant to a member's intellectual, cognitive, and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall psychological and neuropsychological functioning. Test results may have important implications for diagnosis and treatment planning. A licensed psychologist performs psychological testing, either in independent practice as a health services provider, or in a clinical setting. Psychology doctoral candidates may test members and interpret test results; provided the evaluation is conducted in a clinical setting, and that the testing is directly supervised and co-signed by a qualified licensed psychologist. Psychology assistants may not test members under the supervision of a psychologist in an independent practice setting. Neuropsychological testing is most often utilized for members with cognitive impairments that impede functioning on a day to day basis.

All testing is subject to the admission and criteria below, however the following guidelines are most common testing issues:

- Testing is approved only for licensed psychologists and other clinicians for whom testing falls within the scope of their clinical license and have specialized training in psychological and/or neuropsychological testing
- **Educational testing** is not a covered benefit, though this may be subject to state and account-specific arrangements. Assessment of possible learning disorder or developmental disorders is provided by school system per federal mandate PL 94-142
- When **neuropsychological testing** is requested secondary to a clear, documented neurological injury or other medical/neurological condition (i.e. Stroke, traumatic brain injury multiple sclerosis), this may be referred to the medical health plan, though this determination may be subject to state and account-specific guidelines. Neurology consult may be required prior to request.
- All tasks involving **projective testing** must be performed by a licensed psychologist or other licensed clinician with specialized training in projective testing and who is permitted by state licensure.

- The expectation is that diagnosis of ADHD can be made by a psychiatric consult and may not require psychological testing.
- Testing requested by the legal or school system is not generally a covered benefit, unless specified by state regulations or account-specific arrangements.

Admission Criteria	Criteria for Tests	Non-Reimbursable Tests
The following criteria must apply: **Psychological Testing 1-3 must be met:** 1. Request for testing is based on need for at least one of the following: a. Differential diagnosis of mental health condition unable to be completed by traditional assessment; b. Diagnostic clarification due to a recent change in mental status for appropriate level of care determination/treatment needs due to lack of standard treatment response. 2. Repeat testing needed as indicated by **ALL** of the following: a. Proposed repeat psychological testing can help answer question that medical, neurologic, or psychiatric evaluation, diagnostic testing, observation in therapy, or other assessment cannot. b. Results of proposed testing are judged to be likely to affect care or treatment of member (e.g., contribute substantially to decision of need for or modification to a rehabilitation or treatment plan). c. Member is able to participate as needed such that proposed testing is likely to be	1. Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the Tests in Print, or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association. 2. Tests are administered individually and are tailored to the specific diagnostic questions of concern.	1. Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., *MMPI* or *PIC)* as a general rule. 2. Group forms of intelligence tests. 3. Short form, abbreviated, or "quick" intelligence tests administered at the same time as the *Wechsler* or *Stanford-Binet* tests. 4. A repetition of any psychological tests or tests provided to the same member within the preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes: a. Following such special forms of treatment or intervention such as ECT; b. Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. 5. Tests for adults that fall in the educational arena or in the domain of learning disabilities. 6. Testing that is mandated by the courts, Department of Children's Services, or

feasible (e.g., appropriate mental status, intellectual abilities, language skills). d. No active substance use, withdrawal, or recovery from recent chronic use and e. Clinical situation appropriate for repeat testing as indicated by **1 or more** of the following: i. Clinically significant change in member's status (e.g., worsening or new symptoms or findings) ii. Other need for interval reassessment that will inform treatment plan 3. The member must have: a. Diagnostic evaluation (including psychosocial functioning), unless subject to state regulation or account-specific arrangements. b. No active withdrawal and/or substance mis-use within 2 months of request. 4. The member is experiencing cognitive impairments.		other social/legal agency in the absence of a clear clinical rationale. **Please Note:** Beacon will *not* authorize periodic testing to measure the member's response to psychotherapy.
Exclusions: Any of the following criteria are sufficient for exclusion from this level of care: 1. Testing is primarily to guide the titration of medication. 2. Testing is primarily for legal purposes, unless specified by state regulations or account-specific arrangements.		

3. Testing is primarily for medical guidance, cognitive rehabilitation, or vocational guidance, as opposed to the **admission criteria** purposes stated above. 4. Testing request appears more routine than medically necessary (e.g., a standard test battery administered to all new members). 5. Interpretation and supervision of neuropsychological testing (excluding the administration of tests) is performed by someone *other than* a licensed psychologist or other clinician whom neuropsychological testing falls within the scope of their clinical license, and who has had specialized in neuropsychological testing. 6. Measures proposed have no standardized norms or documented validity. 7. The time requested for a test/test battery falls outside Beacon Health Options' established time parameters. 8. 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. 9. Symptoms of acute psychosis, confusion, disorientation, etc., interfering with proposed testing validity are present. 10. Administration, scoring and/or reporting of projective testing is performed by someone other than a licensed		

psychologist, or other clinician for whom psychological testing falls within the scope of their clinical licensure and who has specialized training in psychological testing.		

C. NMNC 6.604.03 Applied Behavioral Analysis

Applied Behavioral Analysis **(**ABA) is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behavior and address challenging behavior problems for members with Autism Spectrum Disorders. Often the behavioral challenges are of such intensity that the member's ability to participate in common social activities or education settings is not possible. ABA services include the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment of ABA focuses on treating these behavioral issues by changing the individual's environment. Suggested intensity and duration of applied behavioral analysis (ABA) varies and is not clearly supported by specific evidence; however, most guidelines and evidence reviews suggest at least 15 hours per week over 1 to 4 years, depending on a child's response to treatment (e.g., adjust or discontinue treatment if child not responding as determined by validated objective standards and outcome measures). Systematic reviews and meta-analyses of studies of early intervention ABA found that mean age of members ranged from 18 to 84 months, mean treatment intensity ranged from 12 to 45 hours per week, and treatment duration ranged from 4 to 48 months.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. The member has behavioral symptoms with a DSM or corresponding ICD diagnosis for Autism Spectrum Disorder or other diagnosis as required by state or federal law. 2. The diagnosis is determined by a qualified provider such as a developmental pediatrician, pediatric neurologist, psychiatrist, or independently licensed and credentialed psychologist, or as permitted by state or federal law.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and does not meet criteria. 2. There is no other level of care that would more appropriately address the member's needs. 3. Treatment is still necessary to reduce symptoms and improve function so the member may be treated at a less restrictive level of care. 4. Treatment/intervention plan includes age appropriate, clearly defined behavioral	**Any one of the following must be met:** 1. Member no longer meets admission criteria and/or meets criteria for another level of care. 2. Member's individual treatment plan and goals have been met. 3. Parent / guardian / caregiver is capable of continuing the behavioral interventions. 4. Parent / guardian withdraws consent for treatment. 5. Member is not making progress toward goals, nor is there any expectation of progress.

3. Member has specific, challenging behavior(s) and/or level of functional deficits attributable to the autism spectrum disorder (e.g. self-injurious, stereotypic/repetitive behaviors, aggression toward others, elopement, severely disruptive behaviors) which result(s) in significant impairment in one or more of the following: a. personal care b. psychological function c. vocational function d. educational performance e. social function f. communication disorders 4. The member can be adequately and safely maintained in their home environment and does not require a more intensive level of care due to: imminent risk to harm to self or others or severity of maladaptive behaviors. 5. The member's challenging behavior(s) and/or level of functioning is expected to improve with IBI/ABA. 6. The member is not currently receiving any other in home or office based IBI/ABA services.	interventions with measurable goals to target problematic behaviors. 5. Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives. 6. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 7. There is a documented active attempt at coordination of care with parent(s)/guardian(s), relevant providers, etc., when appropriate. If coordination is not successful, the reasons are documented. 8. Coordination of care and discharge planning are ongoing with the goal of transitioning member to less intensive behavioral intervention and a less intensive level of care.	6. Member's support system is in agreement with the transition/discharge treatment plan.
Exclusions: Any of the following criteria are sufficient for exclusion from this level of care: 1) The individual has medical conditions or impairments that would prevent beneficial utilization of services.		

2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. 3) The following services are not included within the ABA treatment process and will not be certified: a) Speech therapy (may be covered separately under health benefit) b) Occupational therapy (may be covered separately under health benefit) c) Physical Therapy d) Vocational rehabilitation (may be covered separately under health benefit) e) Supportive respite care f) Recreational therapy g) Orientation and mobility h) Respite care i) Equine therapy/Hippo therapy j) Dolphin therapy k) ABA treatment for diagnoses other than Autism Spectrum Disorder, unless otherwise mandated by state/federal law, or elected by contractual obligation. l) Other educational services		

Section VI: Other Behavioral Health Services

A. NMNC 6.601.02 Electro-Convulsive Therapy

Electro-Convulsive (ECT) Therapy is a procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity while the member is under general anesthesia. This procedure can be administered in a variety of settings, ranging from a licensed hospital to outpatient settings. The decision to pursue ECT treatments is based on a risk/benefit analysis based on the member's history, medical issues, symptomatology, and anticipated adverse side effects. Providers must complete a work-up including medical history, physical examination, and any indicated pre-anesthetic lab work to determine whether there are contraindications to ECT-related anesthesia and that there are no less intrusive alternatives before scheduling administration of ECT. The member must, as required by state or federal specific requirements, provide separate written informed consent to ECT on forms provided by the specific state mental health agency, as consent to other forms of psychiatric treatment are considered separate. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.

In general, an acute course of ECT will consist of 3 sessions per week for a total of 6 to 12 sessions. For members who achieve remission with ECT but are not able to maintain remission with pharmacotherapy, ECT may be administered as a maintenance treatment and is provided at a reduced frequency (eg, weekly, biweekly, monthly). Maintenance ECT may be indicated for long-term maintenance when there is evidence that discontinuation or reduction in frequency is likely to result in a relapse.

Initial Authorization Criteria	Continued Authorization Criteria	Discontinuation Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis of major depression, schizophrenia, schizoaffective mood disorder, or other disorder with features that include mania, psychosis, and/or catatonia. 2. Member has been medically cleared and there are no contraindications to ECT (i.e.Intracranial or cardiovascular, or pulmonary contraindications). 3. There is an immediate need for rapid, definitive response due to at least one of the following: a. Significant risk of harm to self or others; b. Catatonia	**All of the following criteria must be met:** 1. The member continues to meet admission criteria. 2. An alternative treatment would not be more appropriate to address the members ongoing symptoms. 3. The member is in agreement to continue treatment of ECT. 4. Treatment is still necessary to reduce symptoms and improve functioning. 5. There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress. 6. The total number of treatments administered is proportional to the severity	**Any one or more of the following criteria**: 1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2. Member withdraws consent for treatment or refuses treatment and does not meet criteria for involuntary mandated treatment. 3. Member is not making progress toward goals, nor is there expectation of any progress. 4. Member's individual treatment plan and goals have been met. 5. Member's natural support (or other support) systems are in agreement with following through with member care, and

c. Intractable manic episode d. Other treatments could potentially harm the member due to slower onset of action. 4. The benefits of ECT outweigh the risks of other treatments as evidenced by at least one of the following: a. Member has not responded to adequate medication trials; b. Member has had a history of positive response to ECT 5. Maintenance ECT, as indicated by all of the following a. Without maintenance ECT member is at risk relapse b. Adjunct therapy to pharmacotherapy c. Sessions tapered to lowest frequency that maintains baseline	of symptoms, rate of clinical improvement, and adverse side effects. 7. There is documented coordination with family and community supports as clinically appropriate. 8. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	the member is able to be in a less restrictive environment.
Exclusions: Any of the following criteria are sufficient for exclusion from this level of care: 1. The individual can be safely maintained and effectively treated with a less intrusive therapy; or 2. 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 individual from this level of care. Such conditions include but are not limited to: 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 anesthetic risk rated as American Society of Anesthesiologists level 4 or 5		

C. NMNC 6.602.02 Repetitive Transcranial Magnetic Stimulation

Description of Services: Repetitive Transcranial Magnetic Stimulation (rTMS) is a noninvasive method of brain stimulation. In rTMS, an electromagnetic coil is positioned against the individual's scalp near his or her forehead. A Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields then induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, repetitive TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures. rTMS does not induce seizures or involve complete sedation with anesthesia in contrast to ECT. The FDA approval for this treatment modality was sought for patients with treatment resistant depression. Additionally, the population for which efficacy has been shown in the literature is that with treatment resistant depression. Generally speaking, in accordance with the literature, individuals would be considered to have treatment resistant depression if their current episode of depression was not responsive to two trials of medication in different classes for adequate duration and with treatment adherence. rTMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. rTMS is not considered proven for maintenance treatment. The decision to recommend the use of rTMS derives from a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member's treatment history, any potential risks, anticipated adverse side effects and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

Initial Authorization Criteria	Continued Authorization Criteria	Discharge Criteria

All of the following criteria must apply:	All of the following criteria must be met:	Any one of the following criteria:
1. The member must be at least 18 years of age. 2. The individual demonstrates behavioral symptoms consistent with unipolar Major Depression Disorder (MDD), severe degree without psychotic features, either single episode or recurrent, as described in the most current version of the DSM, or corresponding ICD, and must carry this diagnosis. 3. Depression is severe as defined and documented by a validated, self-administered, evidence-based monitoring tool (e.g. QID-SR16, PHQ-9, HAM-D or BDI, etc.). 4. The diagnosis of MDD cannot be made in the context of current or past history of manic, mixed or hypomanic episode. 5. The member has no active (within the past year) substance use or eating disorders. 6. Member must exhibit treatment-resistant depression in the current treatment episode with all of the following: a. Lack of clinically significant response (less than 50% of depressive symptoms) b. Documented symptoms on a valid, evidence-based monitoring tool; 7. Medication adherence and lack of response to at least 2 psychopharmacologic trials in the current episode of treatment at the minimum dose and from 2 different medication	1. The member continues to meet admission criteria. 2. An alternative treatment would not be more appropriate to address the members ongoing symptoms. 3. The member is in agreement to continue TMS treatment and has been adherent with treatment plan. 4. Treatment is still necessary to reduce symptoms and improve functioning. 5. There is evidence of objective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress. 6. Treatment is to continue within the authorization period only when continued significant clinical benefit is achieved (evidenced by scales referenced throughout this document) and treatment outweighs any adverse effects. 7. There is documented coordination with family and community supports as appropriate. 8. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	1. The individual has achieved adequate stabilization of the depressive symptoms. 2. Member withdraws consent for treatment. 3. Member no longer meets authorization criteria and/or meets criteria for another level of care, either more or less intensive. 4. The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement (e.g. validated rating scale and behavioral description) and there is no reasonable expectation of progress. 5. Worsening of depressive symptoms such as increased suicidal thoughts/behaviors or unusual behaviors.

classesMember must not meet any of the exclusionary criteria below. 8. rTMS is administered by a US Food and Drug Administration (FDA) cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters. 9. The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available). **The following criteria may apply:** History of response to TMS in a previous depressive episode as evidenced by a greater than 50% response in standard rating scale for depression (e.g., Geriatric Depression Scale (GDS), Personal Health Questionnaire Depression Scale (PHQ-9), Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR) and now has a relapse after remission and meets all other		

authorization criteria.		
Exclusions: Any of the following criteria are sufficient for exclusion from this level of care: 1. The individual has medical conditions or impairments that would prevent beneficial utilization of services. 2. The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. The safety and effectiveness of rTMS has not been established in the following member populations or clinical conditions through a controlled clinical trial, therefore the following are exclusion criteria: 3. Members who have a suicide plan or have recently attempted suicide; 4. Members who do not meet current DSM or corresponding ICD criteria for major depressive disorder; 5. Members younger than 18 years of age or older than 70 years of age; 6. Members with history recent history of active of substance abuse, obsessive compulsive disorder or post-traumatic stress disorder; 7. Members with a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features; 8. Members with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple		

sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS; 9. The presence of vagus nerve stimulator leads in the carotid sheath; 10. The presence of metal or conductive device in their head or body that is contraindicated with rTMS. For example, metals that are within 30cm of the magnetic coil and include but are not limited to cochlear implant, metal aneurysm coil or clips, bullet fragments, pacemakers, ocular implants, facial tattoos with metallic ink, implanted cardioverter defibrillator, metal plates, vagus nerve stimulator, deep brain stimulation devices and stents; 11. Members with Vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators; 12. rTMS is not indicated for maintenance treatment. There is insufficient evidence to support the efficacy of maintenance therapy with rTMS. rTMS for maintenance treatment of major depressive disorder is experimental/investigational due to the lack of demonstrated efficacy in the published peer reviewed literature.		

C. NMNC 6.605.01 Substance Use Laboratory Testing for Drug and Alcohol Use

Description of Services: This clinical criterion relates to laboratory testing used in the initial assessment and ongoing monitoring of drug and alcohol treatment compliance.

The assessment of continued drug use should be based on treatment interactions, behavioral observations as well as mental status and history and physical evaluation. Confrontation of findings consistent with drug use in many cases results in self-disclosure of ongoing substance use. However, the validity of patient's self-reported substance use is not always reliable.

Ambulatory laboratory testing for drugs of abuse is a medically necessary and useful component of chemical dependency treatment. Drug tests results are of importance in treatment programs and in outpatient chemical dependency treatment. General testing should be ongoing, random and more intense earlier in treatment. The drug screen result can influence treatment and level of care decisions. It is important that ordered tests match treatment needs, the documented history and the most current version of the DSM diagnosis.

Admission Criteria	Qualitative Testing	Quantitative Testing
1. The individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM (the most current version of the DSM substance use diagnosis. 2. The tests ordered are within the scope of license of the ordering practitioner.	A screening immunoassay without confirmation or quantitative testing is typically sufficient for ongoing clinical monitoring. 1. Initial screening for substance use disorders, with rapid test immunoassay (5, 10 or 12 panel) and alcohol screening are recommended upon admission for the treatment of substance use disorder. 2. Post admission, screenings are expected and may be approved at a frequency not to exceed three (3) every thirty (30) days. 3. Testing at a frequency greater than three (3) times in thirty (30) days requires rationale documented in medical record and must meet medical necessity. 4. On site Clinical Laboratory Improvement Act (CLIA)-waived testing is preferred as results can rapidly be integrated into	Most positive screening results are confirmed by the patient's self-disclosed admission of substance use. All orders for quantitative testing of drugs of abuse require a positive screening test and shall be performed only for the drug class represented by the positive screening. 1. Documentation of medical necessity for quantitative testing is required in the medical record. 2. Quantitative testing exceeding three (3) procedure codes or drug classes every thirty (30) days requires rationale documented in medical record and must meet medical necessity.

	treatment decisions and clinical assessment.	
Exclusions: ***Any*** *of the following criteria is sufficient for exclusion:* 1. Quantitative testing or drug confirmation testing is excluded from coverage if performed for forensic or legal purposes. 2. Quantitative testing for negative screening results is excluded without written documentation of medical necessity and prior approval. 3. Quantitative testing requires a positive screening test and shall be performed only for the drug class represented by the positive screening. 4. Blood and urine screens ordered for the same drug panel on the same day will not be paid. 5. Quantitative or qualitative drug testing is excluded from coverage without current active treatment (evidenced by authorization, claims or provider attestation) for drug or alcohol treatment at the time of testing.		