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Over the last few years, with the passage of The Federal Mental Health Parity and Addiction Equity Act in 2008 and The Patient Protection and Affordable Care Act in 2010, the health care industry has evolved and increased in complexity. There is increased benefit coverage for people with mental health and substance use conditions, and these new laws have changed the way health care coverage is managed. This has addressed some of the barriers that individuals have faced in obtaining the proper diagnosis and essential treatment for their condition; however, we continue to be faced with a shortage of mental health services and clinicians in many areas of the country. And despite Americans having a more sophisticated understanding of mental illness, along with an increased awareness through exposure on television and in the media, studies continue to show that there is persistent social stigma attached to people with mental illness and substance use disorders.

With over 150 million Americans continuing to be covered under employer-based insurance, and millions more now being covered through the state-based and federal exchanges, it is essential that we work together to renew our focus and take advantage of the advances brought by these new regulations. We also need to turn our remaining challenges into opportunities. Ultimately, we all share the desire to see every individual get the best care that can be provided. In doing so, we have the responsibility to collaborate with each other to leverage each individual’s health care benefits and to deliver the most effective care in the most appropriate setting at the right time.

Several key focus areas are necessary to consider as we engage in a cooperative and inclusive dialogue. They include variations in standards of care across the country and health care disparities for people with mental health diagnoses. There are still significant gaps in service between mental health clinicians and general medical clinicians. This is important not only as we attempt to provide an integrated and holistic health care experience for individuals, but especially since the majority of people with mental health symptoms are currently only treated by primary care physicians.

With all of the complexity in health care, we support practitioners in exercising their professional judgment to make informed decisions and offer quality care. We also support a consistent application of evidence-based guidelines to enhance clinical judgment and to ensure that treatment includes consideration of the practices that have been shown to be most effective for each individual’s condition. In keeping with this commitment, we have developed our Standards and Guidelines - Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders. These Criteria are intended to be a working document to help set expectations and facilitate a shared responsibility. These Criteria do not replace clinical judgment, and we recognize that these Criteria require adaptation to the unique situations of each individual patient.

We hope this document will prove to be a worthwhile resource, and we thank our practitioners for the outstanding work they do in helping individuals to live healthier, more balanced lives. At Cigna, we support open dialogue with our clinician community and all of our customers. We also always welcome ongoing feedback to find ways that we can all work together to better serve you.

Douglas Nemecek, M.D., M.B.A.
Chief Medical Officer – Behavioral Health
Core Principles

General Overview

Cigna is committed to helping the people we serve improve their health, well-being, and sense of security. That is our mission. We realize that this is not possible without the understanding that mental health is equally important to physical health. There is a growing awareness across the United States of the influence of mental health and substance use conditions and the burden they place on individuals, families, and society. We believe that effective treatment for any illness must address mental health and physical health together. In fact, effective mental health and substance use disorder treatment is a cornerstone to driving holistic health and well-being. Taking this holistic view, with our focus on mental health and substance use issues, helps the people we serve be more productive at work, and more importantly, more productive at home with their families and in their communities.

At Cigna, we strongly believe that the core principle that guides behavioral health care is that access to high quality care should be assured for everyone. This is true regardless of the diagnosis, treatment setting, type of clinician, geographic location, or the gender, ethnicity, or socioeconomic background of the individual seeking care. According to the 2005 Institute of Medicine report, “Improving the Quality of Health Care for Mental and Substance-Use Conditions,” there are six dimensions that need to be addressed in achieving high quality care for patients. Quality mental health care needs to be: safe, effective, patient-centered, timely, efficient, and equitable. Acceptance of these six dimensions of care is essential to delivering the most effective and most appropriate care to every patient. This Institute of Medicine report also identifies the importance of patient care being coordinated over time and across people, functions, activities, and treatment settings so that each patient receives the maximum benefit from their treatment services. It is from this core principle that Cigna has developed our Standards and Guidelines - Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders.

Medical Necessity Criteria

Cigna begins with evidence-based guidelines as the basic platform to define established standards of effective care. Scientific evidence is the vital element in the development of an informed decision-making process for patients and their clinicians. Over the last 10 years, the Surgeon General\(^2\), the President's New Freedom Commission on Mental Health\(^3\), and the Institute of Medicine\(^1\) have all produced reports that highlight the importance of improving the dissemination and adoption of evidence-based practices. Effective treatment is ultimately linked to the consistent use of these evidence-based clinical practices and the ability of mental health clinicians to effectively execute these therapies.

Cigna has adopted nationally developed and published guidelines of the American Psychiatric Association, the American Association of Pediatrics and the National Institute on Alcohol Abuse and Alcoholism due to their acceptance as the best of evidence-based practice for mental health and substance use disorders. Our Criteria then serve as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. We have chosen not to adopt private, proprietary level of care guidelines from companies such as McKesson Health Solutions or MCG, but to develop and implement our own. This decision strongly reflects our philosophy that Cigna’s Criteria should reflect the mutual consensus of all of our stakeholders, be transparent and available to everyone, and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

In the development of our Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders, Cigna has listened to the messages and feedback from patients, advocacy groups (MHA and NAMI), professional associations (American Psychiatric Association, American Academy of Child and Adolescent Psychiatrists, American Psychological Association, Association for Ambulatory Behavioral Healthcare, and the American Society of Addiction Medicine), psychiatrists, psychologists, and therapists across the country. We have attempted to incorporate the strongest, evidence-based points into our Criteria. These Criteria then become a working document to help set expectations and to facilitate a joint working relationship and shared responsibility between Cigna and mental health and substance use disorder clinicians.
Cigna is proud to keep the development process of our Criteria open and transparent to the public. We appreciate the active and meaningful role that patients, clinicians, and advocates have in determining how the scientific evidence is applied in our Criteria. In addition to listening to their input, we have also worked to write our Criteria in words that everyone can understand. Our Criteria are only of value when we can have open, clear, and complete discussions, and when both individuals and their clinicians can understand and use the Criteria in their behavioral healthcare decision making.

Cigna believes that all treatment decisions that are made in alignment with these Criteria must be first and foremost clinically based. Care must be patient-centered and take into account the individuals’ needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual. In this way, the Criteria promote advocacy for the patient and enhance the collaboration between Cigna and clinicians to achieve optimal, patient-centered outcomes. They also promote consistent communication and coordination of care from one treatment setting to the next.

Providing every individual with access to quality, evidence-based, patient-centered care is the core tenet of our philosophy at Cigna. It is from this philosophy that our Standards and Guidelines - Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders help drive improvements in holistic health care and ensure consistent, meaningful outcomes for everyone.

Douglas Nemecek, M.D., M.B.A.
Chief Medical Officer – Behavioral Health

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1Improving the Quality of Health Care for Mental and Substance Use Conditions. Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board of Health Care Services. Washington DC: National Academies Press, 2005.


3Achieving the Promise: Transforming Mental Health Care in America. The President’s New Freedom Commission on Mental Health, Department
Mental Health Treatment for Adults

SECTION 1
Acute Inpatient Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Acute Psychiatric Hospitalization for Adults is utilized when the following services are needed:

› Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring
› Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others,
› Daily monitoring of psychiatric medication effects and side effects, and
› A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Psychiatric Hospitalization for Adults:

› Prior to admission, there has been a face-to-face individual assessment by a licensed behavioral health clinician, with training and experience in the assessment and treatment of acute psychiatric disorders, to determine if this level of care is medically necessary and clinically appropriate.
› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Acute Psychiatric Hospitalization for Adults:

› A thorough Psychiatric Evaluation is completed within 24 hours of admission.
› Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist.
› Psychiatric follow-up occurs daily or more frequently as needed.
› A medical evaluation is completed as needed or appropriate.
› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
› Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
The facility will rapidly assess and address any urgent behavioral and/or physical issues.

**Family Involvement** – Prompt, timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.

- **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
  - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
  - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.

- **Discharge planning.**

**An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:

- A focus on the issues leading to the admission.

- If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.

- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.

- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.

- The goal is to improve symptoms, develop appropriate discharge criteria and a plan that involves coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**A Discharge Plan** that starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.

- Timely and clinically appropriate aftercare appointments

- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. One or more of the following criteria must be met:

   A. It is very likely that the individual is currently at risk of causing serious bodily harm to him/herself or someone else due to a psychiatric illness, (not due to intentional criminal behavior), as evidenced by:
      i) A recent and serious suicide attempt or threat to others involving deadly intent or plan, OR
      ii) A current expression of suicidal intent or homicidal intent with a plan for bodily harm that has a high possibility of becoming deadly or causing serious injury, OR
      iii) Recent, serious and intentional self-injury along with an inability to develop a reasonable plan for safety so that 24 hour observation, safety measures, and treatment are needed in a secure setting, OR
      iv) Recent violent, impulsive, and unpredictable behavior that is likely to result in harm to the individual or someone else without 24-hour observation and treatment, including the possible use of seclusion and/or restraints in a secured setting.

   OR

   B. It is very likely that serious harm will come to the individual due to a psychiatric illness, and that harm cannot be prevented at a lower level of care as evidenced by:
      i) The individual is unable to care for self (nutrition, shelter, and other essential activities of daily living) due to his/her psychiatric condition so that life-threatening deterioration is expected, OR
      ii) The individual has irrational or bizarre thinking, and/or severe slowness or agitation in movements along with interference with activities of daily living of such severity as to require 24-hour skilled psychiatric/medical, nursing and social service interventions.

   OR

   C. The individual has a secondary condition such that treatment cannot be provided at a less restrictive level of care as evidenced by:
      i) A life threatening complication of an eating disorder, OR
      ii) An active general medical condition (i.e.; cardiac disease, pregnancy, diabetes, etc.) which requires that psychiatric interventions be monitored in a 24-hour psychiatric/medical setting, OR
      iii) The individual requires Electroconvulsive Therapy (ECT) and the initial trial requires a 24-hour psychiatric/medical setting.

   OR

   D. Appropriate less restrictive levels of care are unavailable for safe and effective treatment.
Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and modification to the treatment plan identifying and addressing specific barriers to achieving that improvement when clinically indicated, OR

   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.

   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

   C. Continued stay is not primarily due to a lack of external supports.
Residential Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Psychiatric Residential Treatment for Adults:

› A Psychiatric Residential Treatment Facility (PTRF) for Adults is either a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose and that includes 7-day a week, 24-hour supervision and monitoring.
  – Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
  – Psychiatric Residential Treatment Facilities are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible Psychiatrist who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  – The program provides for the mental health and physical health needs of the individual.
  – A nurse is on-site and a psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.

› Treatment is focused on stabilization and improvement of functioning and reintegration with family or significant others.
  – Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued ambulatory treatment services as needed.
  – Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.
  – Residential treatment coverage is not based on a preset number of days.
  – The length of a standardized program such as a “30-Day Treatment Program” is not considered as a medically necessary reason for admission and/or continued stay at this level of care.

› Residential treatment is not a substitute for a lack of available supportive living environment(s) in the community.
Exclusions:

- There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Psychiatric Residential Treatment Facilities (PRTF), or the equivalent, and that do not meet the above criteria. A few examples follow:
  - **Therapeutic Group Homes:** These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.
  - **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** These programs may provide therapeutic alternatives for troubled and struggling youth, teens and adults, offering experiential learning and personal growth through outdoor and adventure-based programming. However, they do not utilize a multidisciplinary team that includes psychologists, psychiatrists, and licensed therapists who are consistently involved in the care of the individual. These programs nearly universally do not meet standards for certification as psychiatric residential treatment programs or the quality of care standards for medically supervised care provided by licensed mental health professionals. (11)
  - **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration or simply as respite or housing.
  - **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

**Admission Considerations for Psychiatric Residential Treatment for Adults:**

- Within 72 hours prior to admission, there has been a face-to-face assessment with the individual and family by a licensed behavioral health professional. This assessment includes a clinically-based recommendation for the need for this level of care.

- The admissions process should also include:
  - A documented diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  - Evaluation by a Board Certified/Board Eligible Psychiatrist within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  - A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
  - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
  - Discharge planning.

**Expectations for Psychiatric Residential Treatment:**

- Residential treatment should occur as close as possible to the home and community to which the individual will be discharged
  - If out-of-area placement is unavoidable, there must be consistent family involvement with the individual, and regular family therapy and discharge planning sessions, unless clinically contraindicated,

- Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information
Family Involvement – Prompt, timely family involvement of family/significant others is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** - The family/significant others are needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

- **Family therapy** should occur at least weekly, unless clinically contraindicated, and should be on a face-to-face basis.
  - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
  - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.

- **Discharge planning** that starts at the time of admission.

A Preliminary Treatment Plan is completed within 48 hours of admission and a **Comprehensive Treatment Plan** is to be completed within 5 days that includes:

- A clear focus on the issues leading to the admission and on the symptoms that needs to improve to allow treatment to continue at a less restrictive level of care.

- Multidisciplinary assessments of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and the living situation.

- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

- The family/significant others in at least weekly therapy or, if the family lives greater than 3 hours from the facility, weekly telephone contact for family therapy must be conducted with face-to-face family therapy sessions as frequently as possible.

- Realistic, specific, measurable, and achievable goals.

- This plan should:
  - Be developed jointly with the individual and family/significant others.
  - Include multidisciplinary assessments.
  - Establish measurable goals and objectives.
  - Include treatment modalities that are appropriate to the clinical needs of the child.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

- Discharge planning will start at the time of admission and include:
  - Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
  - Timely and clinically appropriate aftercare appointments, with at least one appointment within 7 days of discharge.
  - Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.
Medical Necessity Criteria - Psychiatric Residential Treatment for Adults

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. One or more of the following criteria must be met:
   
   A. The individual has been diagnosed with a severe psychiatric disorder that is pervasive and significantly impairs functioning. This impairment in function is seen across multiple settings such as work, home, and in the community, and clearly demonstrates a need for 24-hour supervision and active treatment, OR
   
   B. Immediate prior treatment in a more intensive level of care (such as mental health inpatient) has resulted in an acceptable degree of stability. However, the individual continues to display behaviors due to a treatable psychiatric disorder that require supervision and additional active treatment in a 24-hour structured setting in order to return to a level of functioning at which treatment can safely and effectively continue at a less restrictive level of care.

3. All of the following criteria must be met:
   
   A. The individual demonstrates chronic dysfunction, which is likely to respond to multiple therapeutic and family treatment interventions, and the individual and family commit to active regular treatment participation
   
   B. The individual is able to function with some independence, participate in structured activities in a group environment, and is capable of developing the skills necessary for functioning outside of the residential program.
   
   C. Less restrictive or intensive levels of treatment are not appropriate to meet the individual’s needs.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:

   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Partial Hospitalization Mental Health Treatment for Adults

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Psychiatric Partial Hospitalization for Adults

› Provides coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety with support systems in the community.
› Treatment provided in this setting is similar in nature and intensity as that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.
› Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
  – “Partial hospitalization programs (PHP’s) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu.”(7)
  – PHP’s may pursue one or both of the following major functions:
    • Acute Crisis Stabilization
    • Acute Symptom Reduction.
› Partial hospitalization programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system
› An Individual in Psychiatric Partial Hospitalization for Adults:
  – Is not appropriate for PHP service level if he/she is imminently at risk of suicide or homicide and without sufficient impulse/behavioral control and/or minimum necessary social support.
  – Is having acute psychiatric symptoms that are compromising daily functioning with work, school, and/or with other activities of daily living
  – Has the ability:
    • To make basic decisions for him/herself AND
    • To accept responsibility for his/her own actions
Admission Considerations for Psychiatric Partial Hospitalization for Adults:

› Within 72 hours prior to admission, there has been a face-to-face assessment by a licensed behavioral health professional. This assessment includes a clinically-based recommendation for the need for this level of care.

› The admissions process should also include:
  – A documented current diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  – Evaluation by a Board Certified/Board Eligible Psychiatrist within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  – A medical assessment and physical examination within the first 72 hours of admission, unless a physician determines that a recent examination prior to admission to the facility was sufficient.
  – Identification of family and/or community resources and family participation in treatment when indicated.
  – Discharge planning.

Expectations for Psychiatric Partial Hospitalization for Adults:

› Individuals who are at this level of care:
  – Are typically in a structured treatment program 5 days per week.
  – At a minimum, 20 hours of scheduled programming extended over at least five (5) days per week are to be provided.
  – Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills.
  – Live in the community without the restrictions of a 24-hour supervised setting during non-program hours.
  – Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Partial Hospitalization programs, as this is an ambulatory service. However, during non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.

› The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.

› During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist

› Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  – Assessment – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
  – Family therapy is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
• Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

– **Discharge planning.**

› An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:
  – A focus on the issues leading to the admission.
  – Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.
  – All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
  – The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  – Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
  – Clear, objective and observable discharge criteria.
  – A discharge plan that includes coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

› **The Discharge Plan** starts at the time of admission and includes:
  – Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
  – Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
  – A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Note:** This level should not be confused with sub-acute “Day Programs" where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.

### Medical Necessity Criteria – Psychiatric Partial Hospitalization for Adults

#### Criteria for Admission

1. **All of the following must be met:**
   A. All elements of Medical Necessity must be met.
   B. The individual has a documented primary diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

2. **One or more of the following must be met:**
   A. The individual is demonstrating significant impairments in functioning secondary to a psychiatric disorder, as evidenced by both of the following:
      i) The individual is not able to complete routine daily social, family, school, and/or work activities, AND
ii) The individual is not able to employ the necessary coping skills to compensate for this.

B. The individual has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24-hour monitoring environment, OR

C. The individual requires a structured program to avoid complications of a co-existing medical condition (e.g., pregnancy, uncontrolled diabetes)

3. **All of the following must be met:**
   
   A. The individual is mentally and emotionally capable to actively engage in the treatment program
   
   B. The individual is able to live in the community without the restrictions of a 24-hour supervised setting.
   
   C. The individual is expressing willingness to engage in treatment.
   
   D. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
   
   E. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR- If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
   
   F. If there are medical issues, they can be safely managed in a partial hospital level of care.

**Criteria for Continued Stay**

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Intensive Outpatient Mental Health Treatment for Adults

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.


**Description – Psychiatric Intensive Outpatient Treatment for Adults** provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety w/ support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

Intensive Outpatient programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.

- An Individual in Psychiatric Intensive Outpatient Treatment for Adults:
  - Has the ability:
    - To make basic decisions for him/herself AND
    - To accept responsibility for his/her own actions and behavior,
  - Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
  - The individual is not at imminent risk for serious bodily harm toward self or others.
  - Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
  - This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant immediately returned to a less structured outpatient setting.

**Admission Considerations for Psychiatric Intensive Outpatient Treatment for Adults**:

- Prior to admission, there has been a face-to-face individual assessment by a licensed behavioral health clinician, to determine if this is a level of care that is medically necessary and clinically appropriate.
- Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
Expectations for Psychiatric Intensive Outpatient Treatment for Adults:

- Individuals who are at this level of care:
  - Are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
  - Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills.
  - Live in the community without the restrictions of a 24-hour supervised setting during non-program hours.
  - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.
  - Cigna does not cover boarding for Intensive Outpatient programs as this is an ambulatory service. However, during non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.

- The facility provides a structured program, which is staffed by professionals who are trained and experienced in the treatment of mental disorders.

- A psychiatrist is available for consultation, as needed.

- An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:
  - A focus on the issues leading to the admission.
  - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and living situation.
  - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
  - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
  - Clear, objective and observable discharge criteria.
  - A discharge plan that includes coordination with family and community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

- **Family Involvement** - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  - **Assessment** - The family is needed to provide *detailed initial history* to clarify and understand the current and past events leading up to the admission.
  - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
• Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

  – **Planning for Discharge**

  › **A Discharge Plan** that starts at the time of admission and includes:

    – Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
    
    – Timely and clinically appropriate aftercare appointments
    
    – A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

### Medical Necessity Criteria – Psychiatric Intensive Outpatient Treatment for Adults

#### Criteria for Admission

**All of the following must be met**

1. All elements of Medical Necessity must be met.

2. The individual has a documented primary diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. The individual is demonstrating difficulties in functioning secondary to a psychiatric disorder as evidenced by:

   A. The individual is mildly to moderately impaired in his/her ability to complete routine daily social, family, school, and/or work activities, AND
   
   B. The individual is able to employ the necessary coping skills to continue with most routine daily activities.

4. The individual is mentally and emotionally capable to actively engage in the treatment program

5. The individual is able to live in the community without the restrictions of a 24-hour supervised setting.

6. The individual is expressing willingness to engage in treatment.

7. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.

8. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

#### Criteria for Continued Stay

**All of the following must be met**:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**

   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Mental Health Treatment for Children and Adolescents

SECTION 2
Acute Inpatient Mental Health Treatment for Children and Adolescents

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

**Description – Acute Psychiatric Hospitalization** for Children and Adolescents is utilized when the following care services are needed:

› Around-the-clock intensive psychiatric/medical and nursing care, including continuous observation and monitoring.
› Acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others.
› Daily monitoring of psychiatric medication effects and side effects and
› A contained environment for specific treatments that could not be safely done in a non-monitored setting.

**Admission Considerations for Acute Psychiatric Hospitalization for Children and Adolescents:**

› Prior to admission, there has been a face-to-face assessment by a licensed behavioral health clinician, with training and experience in the assessment and treatment of acute psychiatric disorders in children and adolescents, to determine if this level of care is medically necessary and clinically appropriate.
› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

**Expectations for Acute Psychiatric Hospitalization for Children and Adolescents:**

› A thorough Psychiatric Evaluation is completed within 24 hours of admission
› Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified Child Psychiatrist.
› Psychiatric follow-up occurs daily or more frequently as needed.
› A medical evaluation is completed within 24 hours of admission.
› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
Within 48 hours of admission, outreach will be done with existing providers and family members to obtain any relevant history and clinical information.

Young children (12 years and younger) will be admitted to a unit exclusively for children.

Ongoing academic schooling is provided to facilitate a transition back to the child’s previous school setting.

The facility will rapidly assess and address any urgent behavioral and/or physical issues.

**Family Involvement** - The treatment should be family-centered with both the patient and the family included in all aspects of care. Therefore, Prompt, timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

- **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
  
  • However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
  
  • Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.

- **Discharge planning.**

**An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:

- A focus on the issues leading to the admission.

- If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.

- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and living situation.

- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, and family therapies as appropriate.

- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**A Discharge Plan** that starts at the time of admission and include:

- Coordination with family, outpatient providers, and community resources to facilitate a smooth transition back to home, family, work or school, and appropriate less restrictive treatment services.

- Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.

- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.
Medical Necessity Criteria – Acute Psychiatric Hospitalization for Children and Adolescents

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. The child/adolescent has a documented diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. One or more of the following criteria must be met:

   A. It is very likely that the child/adolescent is currently at risk of causing bodily harm to him/herself or someone else due to a psychiatric illness, and not due to intentional criminal behavior, as evidenced by:

      i) A recent and serious suicide attempt or threat to others involving deadly intent or plan, OR

      ii) A current expression of suicidal intent or homicidal intent with a plan for bodily harm that has a high possibility of becoming deadly or causing serious injury, OR

      iii) Recent, serious and intentional self-injury along with an inability to develop a reasonable plan for safety so that 24 hour observation, safety measures, and treatment are needed in a secure setting, OR

      iv) Recent violent, impulsive and unpredictable behavior that is likely to result in harm to the individual or someone else without 24-hour observation and treatment, including the possible use of seclusion and/or restraints in a secured setting.

   B. It is very likely that serious harm will come to the child/adolescent due to a psychiatric illness, and that harm cannot be prevented at a lower level of care as evidenced by:

      i) The child/adolescent is unable to care for self (nutrition, shelter, and other essential activities of daily living) due to his/her psychiatric condition so that life-threatening deterioration is expected, OR

      ii) The child/adolescent has irrational or bizarre thinking, and/or severe slowness or agitation in movements, along with interference with activities of daily living of such severity as to require 24-hour skilled psychiatric/medical, nursing and social service interventions.

   C. The child/adolescent has a secondary condition such that treatment cannot be provided at a less restrictive level of care as evidenced by:

      i) Serious medical complications of an eating disorder,

      ii) An active general medical condition (i.e.; cardiac disease, pregnancy, diabetes, etc.) which requires that psychiatric interventions be monitored in a 24-hour psychiatric/medical setting, OR

      iii) The child/adolescent requires Electroconvulsive Therapy (ECT) and the initial trial requires a 24-hour psychiatric/medical setting, OR

   D. Appropriate less restrictive levels of care are unavailable for safe and effective treatment.
Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Residential Mental Health Treatment for Children and Adolescents

Standards and Guidelines:

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Psychiatric Residential Treatment for Children and Adolescents:

› Cigna agrees with the following principles, as stated by the American Academy of Child and Adolescent Psychiatry (11):
  – "The best place for children and adolescents is at home with their families. A child or adolescent with mental illness should be treated in the safest and least restrictive environment, and needed services should be 'wrapped-around' to provide more intensive home or community-based services.
  – However, due to the severity of an individual's psychiatric illness, there are times when a patient's needs cannot be met in a community-based setting.
  – When less restrictive resources are either unavailable or not appropriate for the patient's needs, it might be necessary for a child or adolescent to receive treatment in a psychiatric residential treatment center (RTC)."

› A Psychiatric Residential Treatment Facility (PRTF) for Children and Adolescents is either a stand-alone mental health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose with 7-day a week, 24-hour supervision and monitoring.
  – Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
  – Psychiatric Residential Treatment Facilities for Children and Adolescents are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  – The program provides for the child’s developmental, emotional, physical and educational needs, including intensive mental health care, physical health care, and access to on-going education at the appropriate developmental level.
– A nurse is on site and a psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.

› Treatment is focused on stabilization and improvement of functioning and reintegration with parents/relatives or guardians,
  – Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued ambulatory treatment services as needed.
  – Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.
  – Residential treatment coverage is not based on a preset number of days.
  – The length of a standardized program such as a “30-Day Treatment Program” is not considered as a medically necessary reason for admission and/or continued stay at this level of care.

› Residential Treatment is not a substitute for lack of available supportive living environment(s) in the community.

Exclusions

› There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Psychiatric Residential Treatment Facilities (PRTF), or the equivalent, and that do not meet all of the above criteria. A few examples follow:
  – **Therapeutic Group Homes**: These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.
  – **Therapeutic (Boarding) Schools**: The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.
  – **Wilderness Programs, Boot Camps, and/or Outward Bound Programs**: These programs may provide therapeutic alternatives for troubled and struggling youth, teens and adults, offering experiential learning and personal growth through outdoor and adventure-based programming. However, “they do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the care of the child or adolescent. These programs nearly universally do not meet standards for certification as psychiatric residential treatment programs or the quality of care standards for medically supervised care provided by licensed mental health professionals.” (11)
  – **Community Alternatives**: The admission is being used for purposes of convenience or as an alternative to incarceration 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.
  – **Environmental Admissions**: Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

**Admission Considerations for Psychiatric Residential Treatment for Children and Adolescents:**

› Prior to the time of admission, there has been a face-to-face assessment with the child/adolescent and family by a licensed behavioral health professional with training and experience consistent with
the age and problems of children and adolescents. This assessment includes a clinically-based recommendation for the need for this level of care.

– The admissions process should also include:

– A documented current diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.

– Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.

– A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.

– Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.

– Discharge planning.

Expectations for Psychiatric Residential Treatment for Children and Adolescents:

› Residential treatment should occur as close as possible to the home and community to which the individual will be discharged

– If out-of-area placement is unavoidable, there must be consistent family involvement with the individual and regular family therapy and discharge planning sessions, unless clinically contraindicated.

› Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information

› Family Involvement – The treatment should be family-centered with both the patient and the family included in all aspects of care. Therefore, prompt, timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

– Assessment - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

– Family therapy should occur at least weekly, unless clinically contraindicated, and should be on a face-to-face basis.

• However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.

• Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.

• Therapeutic passes may occur, when clinically indicated, to allow opportunity to practice therapeutic skills/gains with the family.

– Discharge planning that starts at the time of admission.
Ongoing academic schooling is provided to facilitate a transition back to the child’s previous school setting.

Young children (12 years and younger) will be admitted to a unit exclusively for children.

A Preliminary Treatment Plan is completed within 48 hours of admission and a Comprehensive Treatment Plan is to be completed within 5 days that includes:

- A clear focus on the issues leading to the admission and on the symptoms that need to improve to allow treatment to continue at a less restrictive level of care.
- Multidisciplinary assessments of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and the living situation.
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- The family in at least weekly therapy or, if the family lives greater than 3 hours from the facility, weekly telephone contact for family therapy must be conducted with face-to-face family therapy sessions as frequently as possible.
- Realistic, specific, measurable, and achievable goals.
- This plan should:
  - Be developed jointly with the family and the child/adolescent.
  - Include treatment modalities that are appropriate to the clinical needs of the child.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

Discharge planning will start at the time of admission and include:

- Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
- Timely and clinically appropriate aftercare appointments, with at least one appointment within 7 days of discharge.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Residential Mental Health Treatment for Children and Adolescents:

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. One or more of the following criteria must be met:

   A. The child/adolescent has been diagnosed with a severe psychiatric disorder that is pervasive and significantly impairs developmentally appropriate functioning. This impairment in function is seen across multiple settings such as; school, home, work, and in the community, and clearly demonstrates a need for 24-hour supervision and active treatment, OR
B. Immediate prior treatment in a more intensive level of care (such as mental health inpatient) has resulted in an acceptable degree of stability. However, the child/adolescent continues to display behaviors that require around-the-clock supervision in a structured setting in order to maintain the safety of the child/adolescent and others.

3. **All of the following criteria must be met:**
   
   **A.** The child /adolescent and/or family demonstrate chronic dysfunction, which is likely to respond to multiple therapeutic and family treatment interventions, and all parties commit to active regular treatment participation.
   
   **B.** The child/adolescent is able to function with age-appropriate independence, participate in structured activities in a group environment, and is capable of developing the skills necessary for functioning outside of the residential program.
   
   **C.** Less restrictive or intensive levels of treatment are not appropriate to meet the child/adolescent's needs or have been tried and were unsuccessful.

**Criteria for Continued Stay**

**All of the following must be met:**

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**
   
   **A.** The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   **B.** If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and modification to the treatment plan, when clinically indicated, OR
   
   **C.** The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   **A.** The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   **B.** Continued stay is not primarily for the purpose of providing a safe and structured environment.
Partial Hospitalization Mental Health Treatment for Children and Adolescents

Standards and Guidelines:

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

**Description – Psychiatric Partial Hospitalization for Children and Adolescents** provides coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety w/ support systems in the community.

- Treatment provided in this setting is similar in nature and intensity as that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.
- Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
  - “Partial hospitalization programs (PHP’s) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu.”(7)
  - PHP’s may pursue one or both of the following major functions:
    - Acute Crisis Stabilization
    - Acute Symptom Reduction.
- Partial hospitalization programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.
- An Individual in Psychiatric Partial Hospitalization for Children and Adolescents:
  - Children/adolescents are not appropriate for PHP service level if they are imminently at risk of suicide or homicide and without sufficient impulse/behavioral control and/or minimum necessary social support.
  - Is having acute psychiatric symptoms that are compromising daily functioning with school, work, and/or with other activities of daily living
  - Has the ability:
    - To make age-appropriate basic decisions for him/herself AND
    - To accept responsibility for his/her own actions
Admission Considerations for Partial Hospitalization Mental Health Treatment for Children and Adolescents:

› Within 72 hours prior to admission, there has been a face-to-face assessment with the individual and family by a licensed behavioral health professional. This assessment includes a clinically-based recommendation for the need for this level of care.

› The admissions process should also include:
  – A documented current diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  – Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  – A medical assessment and physical examination within the first 72 hours of admission, unless a physician determines that a recent examination prior to admission to the facility was sufficient.
  – Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
  – Discharge planning.

Expectations for Psychiatric Partial Hospitalization for Children and Adolescents:

› Individuals who are at this level of care:
  – Are typically in a structured treatment program 5 days per week.
  – At a minimum, 20 hours of scheduled programming extended over at least five (5) days per week are to be provided.
  – Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills.
  – Live in the community without the restrictions of a 24-hour supervised setting during non-program hours, other than age appropriate limitations for children and adolescents.
  – Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Partial Hospitalization programs as this is an ambulatory service. However, during non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others, except as age-appropriate for children and adolescents.

› The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.

› During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board Eligible Psychiatrist with training and experience consistent with the age and problems of children and adolescents.

› Family Involvement - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  – Assessment - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
– **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

  - Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

– **Discharge planning.**

  › Ongoing academic schooling is provided to facilitate a transition back to the child’s previous school setting.

  › Young children (12 years and younger) will be admitted to a unit exclusively for children.

  › An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:

    - A focus on the issues leading to the admission.
    - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.
    - All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
    - The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
    - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
    - Clear, objective and observable discharge criteria.
    - A discharge plan that includes coordination with family and community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

› **A Discharge Plan** that starts at the time of admission and includes:

    - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
    - Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
    - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Note:** This level should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.
Medical Necessity Criteria – Psychiatric Partial Hospitalization for Children and Adolescents

Criteria for Admission

1. **All of the following must be met**
   
   A. All elements of Medical Necessity must be met.
   
   B. The child/adolescent individual has a documented diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders,

2. **One or more of the following must be met:**
   
   A. The child/adolescent is demonstrating significant impairments in functioning secondary to a psychiatric disorder, as evidenced by both of the following:
      
      i) The child/adolescent is not able to complete routine daily social, family, school, and/or work activities, AND 
      
      ii) The child/adolescent is not able to employ the necessary coping skills to compensate for this.
   
   B. The child/adolescent has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24-hour monitoring environment, OR
   
   C. The child/adolescent requires a structured program to avoid complications of a co-existing medical condition (e.g., pregnancy, uncontrolled diabetes).

3. **All of the following must be met:**
   
   A. The child/adolescent is mentally and emotionally capable to actively engage in the treatment program
   
   B. The child/adolescent is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.
   
   C. The child/adolescent is expressing willingness to engage in treatment.
   
   D. The child/adolescent and the family are able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
   
   E. The child/adolescent has a support system that includes family or guardians who are able to actively participate in treatment
   
   F. If there are medical Issues, they can be safely managed in a partial hospital level of care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Intensive Outpatient Mental Health Treatment for Children and Adolescents

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.


**Description** – Psychiatric Intensive Outpatient Treatment for Children and Adolescents provides a coordinated, ambulatory, multi-disciplinary, time limited treatment for individuals who can maintain personal safety w/ support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

- Intensive Outpatient programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system.
- An Individual in Intensive Outpatient Treatment for Children and Adolescents:
  - Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
  - Has the ability:
    - To make age-appropriate basic decisions for him/herself AND
    - To accept age-appropriate responsibility for his/her own actions
  - Is not at imminent risk for serious bodily harm toward self or others.
- The duration of treatment and frequency of attendance are re-evaluated and adjusted according to the individual’s severity of signs and symptoms.
- Clinical interventions may include individual, family, and group psychotherapies along with medication management.
- This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant immediately returned to a less structured outpatient setting.

**Note:** Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.
Admission Considerations for Intensive Outpatient Treatment for Children and Adolescents:

› Within 72 hours prior to admission, there has been a face-to-face assessment with the child/adolescent and family by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents. This assessment includes a clinically-based recommendation for the need for this level of care.

› The admissions process should also include:
  – A documented current diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  – Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
  – Discharge planning.

› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Intensive Outpatient Treatment for Children and Adolescents:

› Individuals who are at this level of care:
  – Are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
  – Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills
  – Live in the community without the restrictions of a 24-hour supervised setting during non-program hours, other than age-appropriate limitations for children and adolescents.
  – Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Intensive Outpatient programs as this is an ambulatory service. However, during non-program hours, if an individual is boarding at or near a facility, the individual has the freedom to interact with the community independently, without being accompanied by staff or others, except as age-appropriate for children and adolescents.

› The facility provides a structured program, which is staffed by professionals who are trained and experienced in the treatment and problems of children and adolescents.

› A psychiatrist is available for consultation, as needed.

› An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:
  – A focus on the issues leading to the admission.
  – Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.
  – All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
  – The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  – Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
  – Clear, objective and observable discharge criteria.
A discharge plan that includes coordination with family and community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

Family Involvement - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

- Family therapy will occur in a face-to-face setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Planning for Discharge**

A Discharge Plan that starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.

- Timely and clinically appropriate aftercare appointments

- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Medical Necessity Criteria – Psychiatric Intensive Outpatient Program for Children and Adolescents**

**Criteria for Admission**

All of the following must be met

1. All elements of Medical Necessity must be met.

2. The child/adolescent has a documented primary diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. The child/adolescent is demonstrating difficulties in functioning secondary to a psychiatric disorder to the extent that:
   
   A. The child/adolescent is mildly to moderately impaired in his/her ability to complete routine daily social, family, school, and/or work activities, AND
   
   B. The child/adolescent is able to employ the necessary coping skills to continue with most routine daily activities.

4. The child/adolescent is mentally and emotionally capable to actively engage in the treatment program

5. The child/adolescent is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.

6. The child/adolescent is expressing willingness to engage in treatment.
7. The child/adolescent and the family are able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.

8. The child/adolescent has a support system that includes family or guardians who are able to actively participate in treatment.

**Criteria for Continued Stay**

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Outpatient Behavioral Health Treatment

Standards and Guidelines

› **Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.


**Description – Outpatient Behavioral Health Treatment** has the following focus and goals:

› Reduce or alleviate the individual’s symptoms
› Return individual to baseline or improve the level of functioning and/or
› Prevent imminent deterioration that would lead to a need for admission to a more intensive level of care.

*Outpatient Treatment may consist of Individual Therapy, Group Therapy, or Family Therapy, Medication Management, or any combination of these four types of treatment.*

**Individual Therapy**

This is a process in which an individual is involved in a therapeutic setting with a mental health or substance abuse clinician on an individual basis. Individual therapy should be considered when:

› The individual is experiencing symptoms or impairments that are impacting their day to day functioning, relationships, work or school performance.
› The individual has been unable to alleviate their symptoms on their own and/or is in need of additional assistance to relieve their symptoms.

**Group Therapy**

This is a process in which a number of people are involved in a therapeutic setting at the same time under the guidance of a mental health or substance abuse clinician. Groups focus on an individual within the context of a group, on interactions that occur among individuals in the group, or on the group as a whole.

Group therapy may be considered when:

› Problems are best treated in a social context,
› Peer group interaction will enhance the effectiveness of problem solving,
› Creating bonds or learning about the impact one has on others is important for symptom resolution and growth, or
› Useful solutions may be better heard from peers.
Family Therapy
The identified patient in family therapy may be a child, adolescent or adult. Family therapy should be considered when:

› The family is affected by either the individual’s condition or the individual’s treatment.
› The individual’s symptoms or lack of functioning is reflective of family problems.
› The family is compromising the individual’s progress.
› The treatment objectives can most efficiently be achieved by working with the family.
› The individual has failed to make expected progress, and family interventions would be expected to improve treatment progress—indicators include medication noncompliance, failure to maintain abstinence from substance abuse or other self-harming behaviors, recurrent hospitalizations.
› The identified individual is a child/adolescent or a young adult still living at home and/or requires parental resources for appropriate functioning.

Medication Management:

› There are a few biologically-based psychiatric conditions that require long-term, continuous medication management and follow-up to prevent or minimize the frequency and severity of acute symptom relapse that could require higher levels of care;
› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
› The need for ongoing medication management does not necessarily indicate that continued outpatient therapy is medically necessary.

Telehealth
Telehealth is the exchange of medical information from one site to another via electronic communications to improve an individual’s clinical health status. Telehealth is not a subspecialty in psychiatry but a modality for delivery of care. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunication technologies.

Currently, Cigna covers Telehealth services only in states that have enacted laws to mandate coverage. It is Cigna Behavioral Health policy not to cover telephonic sessions.

Telephonic sessions are not considered to be a substitute for face-to-face therapy and are approved only when an individual cannot access direct patient/provider care, either

› Due to being geographically remote or
› When the individual is incapacitated and unable to attend face-to-face treatment, or
› When there is a state law that requires coverage.

These services still need to meet criteria for medical necessity.

Expectations for Outpatient Behavioral Health Treatment:

› The therapist and individual will collaborate to establish clearly defined treatment objectives and to identify ways to measure improvement.
› From time to time, individuals may occasionally have other unresolved problems, but their level of functioning has been restored to baseline. The presence of unresolved issues does not necessarily indicate that continued outpatient therapy is medically necessary.
› The type and degree of functional impairment will be reflected in the treatment plan.
› Treatment will be solution-focused and highly interactive,

› In most cases, there is an expectation that therapy will terminate once the objectives of the treatment episode have been met.

› Extended therapy visits (i.e., sessions lasting more than 50 minutes) and multiple visits per week are not considered medically necessary unless there is a compelling clinical reason for the request.

› For individuals with a history of multiple treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

› Telephonic sessions are not considered to be a substitute for face-to-face therapy and are approved only when an individual cannot access direct patient/provider care, either due to being geographically remote or when the individual is incapacitated and unable to attend face-to-face treatment, or when there is a state mandate of parity for telephonic visits.

› Cigna does not authorize treatment that is not HIPAA compliant. As such, requests for therapy sessions via popular social media apps or other non-HIPAA compliant means of communication cannot be approved.

Note: Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are to be reviewed as group therapy, utilizing the guidelines for Outpatient Mental Health and/or Substance Abuse Treatment.

Medical Necessity Criteria – Outpatient Behavioral Health Treatment

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. For all modalities of psychotherapy ALL of the following must be met:
   A. The individual reports or expresses a subjective level of distress.
   B. Clinical symptoms result in functional impairment (impairment in ability to complete activities of daily living, occupational functioning, and/or social functioning that is not characteristic of the person when not symptomatic)
   C. The individual is motivated for, or amenable to, treatment by a mental health professional.

Criteria for Continued Stay

All of the following must be met:

1. All elements of medical necessity must be met.

2. The individual continues to experience both psychiatric symptoms and functional impairment.

3. The individual (and family as appropriate) has participated in the development of an individualized treatment plan. The treatment plan should include clearly defined, measurable, and realistic goals and discharge criteria, with an expected timeframe for completion.

In addition, Continued Stay guidelines are NOT met if any of the following are the case:

1. The individual is uncooperative or noncompliant with treatment, and the absence of treatment poses no imminent risk of harm to the welfare of the individual or others.

2. The individual's history provides evidence that additional outpatient therapy will not create further symptom relief and/or change.
3. Treatment is primarily supportive in nature.

4. Treatment is focused on phase of life, life transition, or quality of life issues (for example, career dissatisfaction, adjusting to new life circumstances in the absence of functional impairments) rather than on treating a psychiatric illness.
Halfway House for Behavioral Health & Substance Use Disorders

Standards and Guidelines

Note: Halfway House placement is excluded under many Cigna Behavioral Health benefit plans, and may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Halfway House for Behavioral Health Disorders will:

› Be licensed to provide services for individuals with substance abuse disorders and/or other behavioral health disorders by an appropriate state licensing certification board in the state where the care is provided.
› Provide 24-hour monitoring of the individual and the immediate physical environment to ensure a safe, clean and sober environment, where an individual in treatment for substance abuse problems can continue his/her recovery.
› Have clinical oversight provided by licensed medical professionals or substance abuse counselors.
› Have the capability to provide medical and psychiatric referrals for treatment and follow up of underlying physical and/or psychiatric illnesses, and
› Require abstinence from mood-altering chemicals unless appropriately prescribed by a licensed physician.
› Be used for stabilization of the individual and preparation for transition to a less restrictive level of care with a goal of reintegration into the individual’s community.

Admission Considerations for Halfway House for Behavioral Health Disorders:

› A Halfway House admission may be considered when an appropriate, less restrictive level of care is unavailable.
› Relapse should not be the sole criteria for transferring an individual to a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its effects on the individual and family, the risk of danger or harm to the individual or others, and the reason for the relapse. An updated and modified treatment plan should then include addressing the barriers to continued relapse, the relapse triggers, and the prevention plan.
For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Expectations for Halfway House for Behavioral Health Disorders:

› Staff will actively work with the individual to ensure he/she fully participates in substance abuse treatment, which can include on-site or community-based outpatient individual, group, and family treatment, all while residing in the halfway house.

› The staff and program of the Halfway House are focused on reducing the risk of relapse, reinforcing pro-social behaviors, and assisting in community reintegration.

› The Halfway House will have a documented and regularly updated care plan that addresses the individuals’ behavioral health needs.

› The discharge plan will include:
  – Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
  – Timely and clinically appropriate aftercare appointments.

Medical Necessity Criteria – Halfway House for Behavioral Health Disorders

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. All of the following criteria must be met:
   
   A. The individual is medically stable and not experiencing medical complications that would preclude active participation in treatment. The individual is cognitively able to actively participate in and benefit from behavioral health treatment.
   
   B. The individual demonstrates an interest in working toward the goal of rehabilitation.
   
   C. The individual is actively engaged in treatment, which must include on-site or community-based outpatient individual, group, and family treatment, or IOP/PHP, and staff at the halfway house have reviewed and agree with the treatment plan.

3. One or more of the following criteria must be met:
   
   A. While residing in a non-Halfway House setting, the individual:
      
      i) Has been unsuccessful in achieving sustained abstinence of 6 months or more following active participation in an outpatient rehabilitation program (intensive outpatient and/or partial hospitalization) during the past 12 months, OR
      
      ii) Has failed to follow-through with outpatient rehabilitation, including intensive outpatient and/or partial hospitalization, OR
      
      iii) Has demonstrated a repeated inability to control his/her impulses to use drugs/alcohol. For an individual with a history of repeated relapses and treatment history involving multiple treatment episodes, there must be evidence of the rehabilitation potential for the proposed admission, with clear interventions, and definition of noncompliance and its management, OR
   
   B. The individual’s living environment is such that his/her ability to successfully achieve abstinence is jeopardized. Examples would be: the family is opposed to the treatment efforts, the family is actively involved in their own substance abuse, and/or the living situation is severely dysfunctional, OR
C. The individual's social, family, and occupational functioning is severely impaired secondary to substance abuse, such that most daily activities revolve around obtaining, using, and recuperating from substance abuse. While the individual is expressing an interest in abstinence, he/she requires 24-hour supportive living environment to engage and maintain therapeutic gains.

**Criteria for Continued Stay**

All of the following must be met:

1. All elements of medical necessity continue to be met.

2. **One or more of the following criteria must be met:**
   
   A. The individual recognizes or identifies with the severity of the behavioral health problem, however, s/he still:
   
   B. Requires support to maintain continued sobriety, OR
   
   C. Requires support to maintain insight into self-defeating behaviors associated with behavioral health, OR
   
   D. Requires support to maintain the problem solving skills necessary to address their behavioral health, OR
   
   E. Requires support to manage personal triggers associated with relapse.

3. **All of the following must be met:**
   
   A. The individual is actively engaged in on-site or community-based outpatient individual, group, and/or family treatment or IOP/PHP.
   
   B. The individual is actively pursuing independent living arrangements.
   
   C. There is clinical evidence as to why other living arrangements, with or without the use of other treatment services, would not sustain the individual's progress.
   
   D. The individual is improving clinically and progressing towards discharge from the present level of care.
   
   E. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
Substance Use Disorders Treatment

SECTION 4
Acute Inpatient Drug and Alcohol Detoxification

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Acute Inpatient Drug and Alcohol Detoxification is utilized when the following services are needed:

› Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
› Appropriate medical professionals are available, including physician visits at least once each day and 24-hour nursing staff monitoring.
› Daily monitoring of psychiatric medication effects and side effects, and
› A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Drug and Alcohol Detoxification is utilized when the following services are needed:

› This level of care may be considered after the individual has been evaluated medically in a face-to-face assessment prior to the admission to determine if this level of care is medically necessary and clinically appropriate due to a significant risk of a severe withdrawal syndrome.
› This level of care is not justified by simple intoxication or fear of withdrawal. Therefore, elevated blood alcohol level without any associated withdrawal symptoms is not enough to justify detoxification treatment.
› It is recognized that life-threatening intoxication/poisoning (i.e. endangering vital functions – central nervous system, cardiac, respiratory) may need acute medical attention, but that attention is generally not considered detoxification. In such cases, treatment at a medical/surgical unit may be needed and medical necessity criteria are applied when the individual has acute and severe medical problems such as:
  – Acute onset of seizures, severe electrolyte imbalance, gastrointestinal bleeds, cardiac complications, acute liver failure, or other serious medical complications, OR
  – Underlying substance abuse is of such severity that it will likely cause severe and acute medical complications in the near future requiring acute medical management.
Expectations for Acute Inpatient Drug and Alcohol Detoxification:

› A thorough Evaluation by a psychiatrist or addictionologist is completed within 24 hours of admission.

› Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.

› Physician follow-up occurs daily or more frequently as needed.

› Indicated medical evaluations are completed in a prompt, timely manner.

› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

› Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.

› For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.

› The facility must be able to rapidly assess and address any urgent behavioral and/or physical issues.

› Coordination of treatment planning with community treatment providers, employers, or any involved legal authorities is an essential part of treatment and discharge planning.

› **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
  - A focus on the issues leading to the admission
  - Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.
  - Interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  - Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
  - Clear, objective and observable discharge criteria.
  - A discharge plan that includes coordination with family and community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

  *For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

› The Treatment Plan is not based on a pre-established programmed plan or time frames.

› **Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  - **Assessment** – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
  - **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- Discharge planning.

› **A Discharge Plan** that starts at the time of admission and includes:
  - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
  - Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
  - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Medical Necessity Criteria – Acute Inpatient Drug and Alcohol Detoxification**

**Criteria for Admission**

All of the following must be met:

1. All elements of medical necessity must be met.

2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. The individual is at risk for a severe withdrawal syndrome as evidenced by abnormal vital signs (blood pressure, temperature, pulse, and respirations), clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), and one or more of the following:

   A. **Severe Alcohol and/or Sedative-Hypnotic Withdrawal** as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting, clouding of sensorium, delirium, seizures, and/or hallucinations,

      OR

   B. **Severe Opiate Withdrawal** as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, sweating, diarrhea, dilated pupils, irritability, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, and/or yawning,

      OR

   C. **Prior complicated and potentially life-threatening withdrawal** with a history of seizures, delirium tremens, or hallucinations associated with alcohol and/or sedative-hypnotic use or withdrawal.

   AND

4. **One or more of the following must apply:**

   A. The presenting signs and symptoms require active treatment that can only be safely and effectively provided in a 24-hour per day setting with nursing care and daily medical interventions.

   OR

   B. The Individual is currently suffering from symptoms of a severe mental illness or has such irrational or bizarre thinking that he/she could not be safely treated in a less intensive level of care.
Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**

   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

   B. If the treatment plan implemented is not leading to measurable clinical improvements and the individual continues to suffer from severe withdrawal symptoms that require active treatment efforts that can only be provided by around-the-clock intensive nursing care and daily monitoring by a physician, OR

   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.

   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

   C. Continued stay is not primarily due to a lack of external supports.
Ambulatory Drug and Alcohol Detoxification

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Ambulatory Drug and Alcohol Detoxification is utilized when there is a need for medical monitoring of mild to moderate withdrawal symptoms.

› Medications are prescribed and adjusted as indicated to assure that the individual has a safe and effective withdrawal from alcohol, sedative-hypnotic medications, or opiates.
› Appropriate medical professionals are available, which may include a Psychiatrist or an Addictionologist and daily monitoring by nursing staff.
› There is 24 hour access to a physician should unexpected symptoms or worsening of symptoms occur.

Admission Considerations – Ambulatory Drug and Alcohol Detoxification:

› Prior to admission, there has been a face-to-face individual assessment by a licensed physician or nurse practitioner with training and experience in acute psychiatric emergencies and medical detoxification, to determine if this level of care is medically necessary and clinically appropriate.
› The individuals managed at this level of care do not require medical monitoring on a 24 hours a day basis.
› The facility has the ability to step up the individual to an inpatient detoxification level of care, if needed.

Expectations for Ambulatory Drug and Alcohol Detoxification:

› Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.
› This level of care is used as a time-limited level of intervention to stabilize acute withdrawal symptoms, facilitating a transition to lower levels of care when clinically indicated.
› Individuals and/or their families/significant others are capable of accessing emergency services, if needed.
› Individuals in this level of care live in the community without the restrictions of a 24-hour supervised setting.
The program facilitates engagement of individuals in treatment and recovery programs, including community based self-help groups, and development of a social support network to ensure long-term sobriety.

Coordination with community treatment providers, employers, or any involved legal authorities is part of the treatment and discharge planning.

Psychiatric and/or substance use treatment is addressed concurrently, as needed; to improve the individual's potential for recovery.

For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.

**An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:

- A focus on the issues leading to the admission.
- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation).
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- Interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
- **Family therapy** will occur at a level of frequency and intensity needed to achieve the treatment goals.
- Family therapy will occur in a face-to-face setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)
- Planning for Discharge

**A Discharge Plan** that starts at the time of admission that includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care
- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
Medical Necessity Criteria – Ambulatory Drug and Alcohol Detoxification

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.

2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. The individual is at risk for a withdrawal syndrome as evidenced by abnormal vital signs (blood pressure, temperature, pulse, and respirations), clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), and one or more of the following:
   A. Alcohol and/or Sedative-Hypnotic Withdrawal as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting,
   OR
   B. Opiate Withdrawal as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: irritability, lack of appetite, sweating, diarrhea, dilated pupils, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, yawning.

AND

4. The presenting signs/symptoms must be causing clinically significant distress or impairment of social, occupational, or other important area of functioning,

AND

5. The individual does not require around-the-clock nursing care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care,
   OR
   B. If the treatment plan implemented is not leading to measurable clinical improvements and the individual continues to suffer from severe withdrawal symptoms that require active treatment efforts that can only be provided by around-the-clock intensive nursing care and daily monitoring by a physician,
   OR
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.

   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

   C. Continued stay is not primarily due to a lack of external supports.
Acute Inpatient Treatment for Substance Use Disorders

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

**Description – Acute Inpatient Substance Use Disorders Treatment** is utilized when the following services are needed:

› Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.
› Timely assessment and medically-necessary treatment of co-existing acute medical or psychiatric problems.
› Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others.
› Daily monitoring of medication effects and side effects.
› A contained environment for specific treatments that could not be safely done in a non-monitored setting.

**NOTE:** Acute Inpatient Substance Use Disorders Treatment may also be identified as Inpatient Rehabilitation, Mentally Ill Chemical Abuse (MICA) Treatment, or Dual Diagnosis Inpatient Treatment.

**Admission Considerations for Inpatient Treatment for Substance Use Disorders:**

› Prior to admission, there has been a face-to-face individual assessment by a licensed clinician, with experience in acute psychiatric and medical emergencies, to determine if this level of care is medically necessary and clinically appropriate.
› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.
› Alternative medical, substance use detoxification, psychiatric treatment programs, are considered and referrals made when clinically indicated.
› Substance abuse inpatient treatment may be a consideration when appropriate alternative less restrictive levels of care are unavailable.
Expectations for Inpatient Treatment for Substance Use Disorders:

› A thorough Evaluation by a Psychiatrist or Addictionologist is completed within 24 hours of admission.
› Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified Psychiatrist or Addictionologist.
› A medical work-up is completed as needed or appropriate.
› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
› Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
› For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.
 › The facility must be able to rapidly assess and address any urgent behavioral and/or physical issues
› There is adequate nursing support, along with staffing by appropriately-trained clinicians, and availability of appropriate physician expertise (such as Psychiatrist or Addictionologist).
› The facility has the capability of obtaining necessary consultation(s) based on individual’s clinical needs such as pain management specialist for individuals with significant pain issues.
› The facility has the capability of monitoring individual’s daily, medical functioning. Such clinical monitoring may include measurement of the vital signs, performing objective clinical assessment(s) to monitor for prolonged withdrawal and obtaining necessary laboratory work up, as indicated.
› Treatment is focused on initial engagement in substance abuse rehabilitation and development of a plan for successful transition to less restrictive settings and community re-integration.

› An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:
  – A focus on the issues leading to the admission.
  – Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation).
  – The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  – The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.
  – The Treatment Plan is not based on a pre-established programmed plan or time frames.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

› Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  – Assessment – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
Family therapy is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

- Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

Discharge planning.

A Discharge Plan that starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Acute Inpatient Treatment for Substance Use Disorders

**Criteria for Admission**

**All of the following must be met:**

1. All elements of medical necessity must be met.
2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. **All of the following must be met:**
   
   A. Withdrawal symptoms, if present, are not life threatening and can be safely monitored.
   
   B. The individual is not experiencing medical complications that would preclude active participation in treatment, **AND**
   
   C. The individual is cognitively able to actively participate and benefit from the treatment provided,
4. **One or more of the following criteria must be met:**

   A. The individual demonstrates a clear and reasonable danger of imminent harm to self or others that is caused by or exacerbated by the current active substance use disorder as evidenced by one of the following:
      
      i) Current plan or intent to harm self with an available and lethal means, **OR**
      
      ii) Highly lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety. **OR**

   B. Inability to care adequately for one’s physical safety due to disordered, disorganized or bizarre behavior, **OR**

   C. Current plan/intent to harm others with available and lethal means with inability to plan reliably for safety, **OR**

   D. Violent, unpredictable, or poorly controlled behavior that represents an imminent serious harm to others, **OR**

   E. The individual’s medical condition and continued substance use places the individual in imminent danger of serious damage to his/her physical health or to a current pregnancy. The individual requires 24 hour monitoring, but not the full resources of an acute care hospital, **OR**

   F. Less restrictive levels of care are unavailable for safe and effective treatment.
Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity,

2. At least one of the following criteria must be met:
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   C. Continued stay is not primarily due to a lack of external supports.
Residential Substance Use Disorders Treatment

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Substance Use Residential Treatment:

› A Substance Use Residential Treatment Facility is either a stand-alone substance abuse/ health facility or a physically and programmatically-distinct unit within a facility licensed for this specific purpose with 7-day a week, 24-hour supervision and monitoring.
  – Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.
  – Substance Abuse Residential Treatment Facilities are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible Psychiatrist or Addictionologist who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  – A nurse is on site and a psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.

› Treatment is focused on stabilization and improvement of functioning and not primarily for the purpose of maintaining long-term gains made in an earlier program.
  – Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued ambulatory treatment services as needed.
  – Residential treatment coverage is not based on a preset number of days.
  – The length of a standardized program such as a “28-Day Treatment Program” is not considered as a medically necessary reason for admission and/or continued stay at this level of care.

› Residential treatment is not a substitute for a lack of available supportive living environment(s) in the community.

Exclusions:

› There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Residential Treatment Facilities for Substance Use Disorders and that do not meet all of the above criteria. A few examples follow:
- **Therapeutic Group Homes**: These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.

- **Therapeutic (Boarding) Schools**: The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.

- **Wilderness Programs and/or Outward Bound Programs**: These are programs that provide therapeutic alternatives to boot camps for troubled and struggling youth, teens and adults, offering experiential learning and personal growth through outdoor and adventure-based programming. However, they do not utilize a multidisciplinary team that includes psychologists, psychiatrists, physicians, and licensed therapists who are consistently involved in the care of the individual. These programs nearly universally do not meet standards for certification as residential treatment programs for substance use disorders or the quality of care standards for medically supervised care provided by licensed mental health professionals.(11)

- **Community Alternatives**: The admission is being used for purposes of convenience or as an alternative to incarceration within the justice system 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.

- **Environmental Admissions**: Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

**Admission Considerations for Substance Use Residential Treatment**:

› Prior to the time of admission, there has been a face-to-face evaluation with the individual and family/significant others by a licensed behavioral health professional with training and experience in the assessment and treatment of individuals with substance use disorders. This assessment includes a clinically-based recommendation for the need for this level of care.

› The admissions process should also include:
  - A documented current diagnosis of a psychiatric disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  - Evaluation by a Board Certified/Board Eligible Psychiatrist or Addictionologist within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  - A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
  - Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.
  - Discharge planning.

**Note**: Relapse should not be the sole criterion for managing an individual in a more intensive level of care. When appropriate, an evaluation should be performed to assess the extent of the relapse, its
effects on the individual and the family; the risk of danger or harm to the individual or others; and the reason for the relapse.

**Expectations for Substance Use Residential Treatment:**

› Residential treatment should occur as close as possible to the home and community to which the individual will be discharged
  
  – If out-of-area placement is unavoidable, there must be consistent family involvement with the individual, and regular family therapy and discharge planning sessions, unless clinically contraindicated,

› Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information.

› For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.

› **Family involvement** – Prompt, timely family involvement of family/significant others is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  
  – **Assessment** - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

  – **Family therapy** should occur at least weekly, unless clinically contraindicated, and should be on a face-to-face basis.

  • However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.

  • Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.

  – **Discharge planning** that starts at the time of admission.

› **A Preliminary Treatment Plan** is completed within 48 hours of admission and a **Comprehensive Treatment Plan** is to be completed within 5 days that includes

  – A clear focus on the issues leading to the admission and on the symptoms that needs to improve to allow treatment to continue at a less restrictive level of care.

  – Multidisciplinary assessments of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and the living situation.

  – All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

  – The family/significant others in at least weekly therapy or, if the family lives greater than 3 hours from the facility, weekly telephone contact for family therapy must be conducted with face-to-face family therapy sessions as frequently as possible.

  – Realistic, specific, measurable, and achievable goals.

  – This plan should:

    • Be developed jointly with the individual and family/significant others.

    • Include treatment modalities that are appropriate to the clinical needs of the individual.
For individuals with a history of multiple relapses and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

Discharge planning will start at the time of admission and include:

- Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
- Timely and clinically appropriate aftercare appointments, with at least one appointment within 7 days of discharge.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Residential Substance Use Disorders Treatment

Criteria for Admission

1. All of the following must be met:
   A. All elements of medical necessity must be met.
   B. The individual is expressing willingness to actively participate in this level of care.
   C. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

2. None of the following are present:
   A. Life-threatening symptoms of withdrawal.
   B. Current withdrawal symptoms that preclude active participation in treatment.
   C. Medical or psychiatric impairments that preclude active participation in treatment.

3. For individuals with a history of repeated relapses and/or multiple failed treatment episodes, he/she is expected to actively engage in the implementation of a treatment plan that specifically addresses prior non-adherence and poor response to treatment and includes elements that are likely to reduce the frequency and severity of future relapse.
   AND

4. One or more of the following criteria must be met:
   A. The individual suffers from a severe, uncontrolled, co-occurring psychiatric illness or severe behavioral disturbance that interferes with his/her ability to successfully participate in a less restrictive level of care
   B. The individual's living environment is such that his/her ability to successfully achieve abstinence is seriously jeopardized by either:
      i) A home environment that includes family/significant others that are actively opposed to the treatment efforts, or
      ii) A home environment that includes family/significant others that are actively involved in their own substance abuse
   C. The individual's social, family, or occupational functioning is severely impaired secondary to substance abuse such that most of his/her daily activities revolve around obtaining, using and recuperating from substance abuse,
D. The individual has demonstrated an inability to achieve sustained sobriety at less restrictive levels of care, as evidenced by one of the following:

i) In the past 12 months, the individual has not been successful in achieving sustained abstinence of 6 months or more following active engagement in multiple outpatient rehabilitation programs, including intensive outpatient treatment and/or partial hospitalization.

OR

ii) In the past 12 months, following multiple inpatient detoxifications, the individual has not attempted to follow-up with outpatient rehabilitation programs, including intensive outpatient treatment and/or partial hospitalization.

E. The individual has demonstrated a repeated inability to control his/her impulses to use illicit substances and is at imminent risk of causing (medical or behavioral) harm to self or others. This is of such severity that it requires 24-hour monitoring/support/intervention.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:

   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR

   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.

   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

   C. Continued stay is not primarily due to a lack of external supports.
Partial Hospitalization for Substance Use Disorders

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;

› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.


**Description – Partial Hospitalization for Substance Use Disorders** provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety w/ support systems in the community.

› Treatment provided in this setting is similar in nature and intensity as that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.

› Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):

   – “Partial hospitalization programs (PHP’s) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu.”(7) PHP’s may pursue one or both of the following major functions:

     • Acute Crisis Stabilization
     • Acute Symptom Reduction.

› Partial hospitalization programs may be free standing, part of a behavioral health organization, or a department within a general medical healthcare system.

› An Individual in Partial Hospitalization for Substance Use Disorders:

   – May present ongoing risk of harm to him/her or others, but is able to develop a plan to maintain safety in the community without 24-hour supervision.

   – Is having acute Substance Use Disorder symptoms that are compromising daily functioning with work, parenting, school, and/or with other activities of daily living

   – Has the ability:

     • To make age-appropriate basic decisions for him/herself AND
     • To accept age-appropriate responsibility for his/her own actions and behavior,
Admission Considerations for Partial Hospitalization for Substance Use Disorders:

› Within 72 hours prior to admission, there has been a face-to-face evaluation by a licensed behavioral health professional with training and experience in the assessment and treatment of substance use disorders. This assessment includes a clinically-based recommendation for the need for this level of care.

› The admissions process should also include:
  – A documented current diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  – Evaluation by a Board Certified/Board Eligible Psychiatrist or Addictionologist within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  – A medical assessment and physical examination within the first 72 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
  – Identification of family and/or community resources and family participation in treatment when indicated.
  – Discharge planning.

Expectations for Partial Hospitalization for Substance Use Disorders:

› Individuals who are at this level of care:
  – Are typically in a structured treatment program 5 days per week.
  – At a minimum, 20 hours of scheduled programming extended over at least five (5) days per week are to be provided.
  – Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills.
  – Live in the community without the restrictions of a 24-hour supervised setting during non-program hours.
  – Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Partial Hospitalization, programs as this is an ambulatory service. However, during non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others, except as age-appropriate for children and adolescents.

› For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.

› The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.

› During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.
Family Involvement - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

- **Assessment** - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
  - Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Discharge planning.**

An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:

- A focus on the issues leading to the admission.

- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.

- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.

- Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,

- Clear, objective and observable discharge criteria.

- A discharge plan that includes coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

The Discharge Plan starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.

- Timely and clinically appropriate aftercare appointments within 7 days of discharge date.

- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Note:** This level should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.
Medical Necessity Criteria – Partial Hospitalization for Substance Use Disorders

Criteria for Admission

1. None of the following are present:
   A. Life-threatening symptoms of withdrawal.
   B. Current withdrawal symptoms that preclude active participation in treatment.
   C. Medical or psychiatric impairments that preclude active participation in treatment.

2. All of the following must be met:
   A. All elements of Medical Necessity must be met.
   B. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
   C. The individual is expressing willingness to actively participate in this level of care.
   D. The individual is mentally and emotionally capable to actively engage in the treatment program.
   E. The individual is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.
   F. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.
   G. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
   H. If there are medical issues, they can be safely managed in a partial hospital level of care.

   For individuals with a history of repeated relapses and/or multiple failed treatment episodes, he/she is expected to actively engage in the implementation of a treatment plan that specifically addresses prior non-adherence and poor response to treatment and includes elements that are likely to reduce the frequency and severity of future relapse.

   AND

3. One or more of the following must be met:
   A. The individual is demonstrating significant impairments in functioning secondary to a substance use disorder, as evidenced by both of the following:
      i) The individual is not able to complete routine daily social, family, school, and/or work activities, AND
      ii) The individual is not able to employ the necessary coping skills to compensate for this.
   B. The individual has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24-hour monitoring environment, OR
   C. The individual requires a structured program to avoid complications of a co-existing medical condition (e.g., pregnancy, uncontrolled diabetes).

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:
A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR

C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Intensive Outpatient Treatment for Substance Use Disorders

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

Description – Intensive Outpatient Treatment for Substance Use Disorders provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety w/ support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

› Intensive Outpatient programs may be free standing, part of a behavioral health organization, or a department within a general medical healthcare system.
› An Individual in Intensive Outpatient Treatment for Substance Use Disorders:
  – Has the ability:
    • To make basic decisions for him/herself AND
    • To accept responsibility for his/her own actions and behavior,
  – Is experiencing psychosocial stressors and often-complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
  – Is not at imminent risk for serious bodily injury due to aggression toward self or others.
  – IOP is appropriate to consider for complex clinical situations that would otherwise result in the need for a more restrictive level of care.
› The duration of treatment and frequency of attendance are continually evaluated and adjusted according to the individual severity of signs and symptoms.
› Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
› This level of care can be the first level of care authorized, to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant returned to a less structured outpatient setting.

Note: Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.
Admission Considerations for Intensive Outpatient Treatment for Substance Use Disorders:

› Within 72 hours prior to admission, there has been a face-to-face individual assessment by a licensed behavioral health clinician, with training and experience in the assessment and treatment of substance use disorders, to determine if this is a level of care that is medically necessary and clinically appropriate.

› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Intensive Outpatient Treatment for Substance Use Disorders:

› Individuals who are at this level of care:
  – Are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
  – Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills
  – Live in the community without the restrictions of a 24-hour supervised setting during non-program hours.
  – Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Intensive Outpatient programs as this is an ambulatory service. However, if an individual is boarding at a facility, during non-program hours, the individual must have the freedom to interact with the community independently, without being accompanied by staff or others, except as age-appropriate for children and adolescents.

› For individuals under the age of 18 who present with a substance use disorder, a face-to-face assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.

The facility provides a structured program, which is staffed by trained professionals in the treatment of chemical dependency and abuse.

› A psychiatrist or addictionologist is available for consultation, as needed.

› An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:
  – A focus on the issues leading to the admission.
  – Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and living situation.
  – All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
  – The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  – The goal is to reduce symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.
Family Involvement - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

– **Assessment** – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

– **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
  
  • Family therapy will occur in a face-to-face setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

  • **Discharge planning.**

A Discharge Plan that starts at the time of admission and includes:

– Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.

– Timely and clinically appropriate aftercare appointments

– A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

Medical Necessity Criteria – Intensive Outpatient Treatment for Substance Use Disorders

**Criteria for Admission**

All of the following must be met

1. All elements of Medical Necessity must be met.

2. The individual has a documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. The individual is expressing willingness to actively participate in this level of care.

4. The individual is demonstrating difficulties in functioning secondary to a substance use disorder to the extent that:

   A. The individual is mildly to moderately impaired in his/her ability to complete routine daily social, family, school, and/or work activities, AND

   B. The individual is able to employ the necessary coping skills to continue with most routine daily activities.

5. The individual is mentally and emotionally capable to actively engage in the treatment program

6. The individual is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.

7. The individual and the family are able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.

8. The individual has a support system that includes family or significant others/guardians who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Eating Disorders
Treatment

SECTION 5
Acute Inpatient Treatment for Eating Disorders

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;

› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and

› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.


**Description – Inpatient Treatment for Eating Disorders** is utilized when the following care services are needed:

› Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring.

› Acute treatments to control behavior and symptoms requiring stabilization.

› Acute management to prevent harm or significant deterioration of functioning and to insure the safety of the individual and/or others.

› Daily monitoring of psychiatric medication effects and side effects.

› A contained environment for specific treatments that could not be safely done in a less-restrictive setting.

**Admission Considerations for Inpatient Treatment for Eating Disorders:**

› Prior to admission, there has been a face-to-face medical and psychiatric evaluation of the individual to determine if this level of care is medically necessary and clinically appropriate.

› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

› The medical evaluation should particularly focus on weight, cardiac status, metabolic status, vital signs, and relevant lab values.

› The level of care determination should not be based on a single or limited number of physical parameters such as weight alone.

› Eating Disorder Inpatient care should be driven by the severity of symptoms present, the level of risk to the patient, and the severity of physical and psychological complications that would require 24-hour medical management and monitoring.

› Most individuals with uncomplicated Bulimia Nervosa or a Binge-Eating Disorder do not meet medical necessity criteria for this level of care unless there are:
  – Severe disabling symptoms that have not responded to a less intensive levels of care, and/or
– Serious concurrent general medical problems (e.g., metabolic abnormalities, hematemesis, vital sign changes, or the appearance of uncontrolled vomiting).

**Expectations for Inpatient Treatment for Eating Disorders:**

› A thorough Psychiatric evaluation is completed within 24 hours of admission.

› A medical evaluation is completed and indicated blood and urine specimens are obtained for laboratory analysis within 24 hours of admission.

› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

› Within 48 hours of admission, outreach will be done with existing providers and family members to obtain any relevant history and clinical information.

› The facility will rapidly assess and address any urgent behavioral and/or physical issues.

**Family Involvement** – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:

– **Assessment** – The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.

– **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

• Family therapy will occur in a face-to-face setting (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

– Discharge planning.

› Ongoing academic schooling is provided for children and adolescents to facilitate a transition back to the child’s previous school setting.

› Young children (12 years and younger) will be admitted to a unit exclusively for children.

› An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:

– A focus on the issues leading to the admission.

– If this is a readmission, clarity on what will be done differently during this admission that will likely lead to improvement that has not been achieved previously.

– Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation).

– The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.

– The goal is to improve symptoms, develop appropriate discharge criteria and planning involving coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

› **Discharge Planning** will start at the time of admission and includes:
– Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
– Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
– Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric appointment.

**Medical Necessity Criteria – Inpatient Treatment for Eating Disorders**

**Criteria for Admission**

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
3. **One or more of the following criteria must be met:**

A. The individual has medical instability with abnormalities in some or all vital signs: heart rate (less than 40 in adults or less than 50 in children/adolescents) temperature (less than 97 F), blood pressure (less than 90/60 mm Hg in adults or less than 80/50 for children/adolescents), orthostatic pulse increase (more than 20 beats per minute), orthostatic blood pressure decrease (more than 10-20 mm), OR

B. The individual has abnormal relevant lab values secondary to the Eating Disorder such as low serum glucose (less than 60 mg/dl), electrolyte imbalances, low potassium (less than 3.2 mEq/L), low phosphorus, or low magnesium, OR

C. The individual has significant medical symptoms secondary to the Eating Disorder such as evidence of dehydration, significantly impaired liver, kidney, or heart function; or poorly controlled diabetes needing acute stabilization, OR

D. The Individual has significant decrease in Ideal Body Weight, as indicated by one of the following:
   i) A Body Mass Index (BMI) less than 16, OR
   ii) For children and Adolescents, a rapid, recent, continuing weight decline due to food refusal. Growth charts should be utilized for children and adolescents.
   iii) BMI is greater than 16 and less than 30, AND there is evidence of one of the following:
      a) Weight loss or fluctuation of two or more pounds per week, OR
      b) Weight loss associated with medical instability unexplained by any other medical condition

E. The individual’s eating disorder symptoms require around the clock medical/nursing intervention.
   i) For issues of imminent risk of harm to self or others, OR
   ii) There is a need to provide immediate interruption of food restriction, excessive exercise, binging and purging, and/or use of laxatives/diet pills/diuretics, OR
   iii) To avoid impending life threatening harm due to medical consequences, OR
   iv) To avoid impending life threatening complications due to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes), OR

F. In addition to a primary eating disorder that requires treatment at this level of care, there is a co-occurring psychiatric disorder and/or risk of self-harm requiring 24 hour medical/nursing intervention, OR
Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   C. Continued stay is not primarily due to a lack of external supports.
Residential Treatment for Eating Disorders

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;

› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and

› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Eating Disorder Residential Treatment:

› An Eating Disorder Residential Treatment Facility is either a stand-alone specialized mental health facility or a physically and programatically-distinct unit within a facility licensed for this specific purpose with 7-day a week, 24-hour supervision and monitoring.

– Treatment facility units and sleeping areas are generally not locked, although they may occasionally be locked when necessary in response to the clinical or medical needs of a particular patient.

– Eating Disorder Residential Treatment Facilities are staffed by a multidisciplinary treatment team under the leadership of a Board Certified/Board Eligible Psychiatrist with training and experience in the assessment and treatment of eating disorders who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.

– The program provides for the mental health and physical health needs of the individual.

– A nurse is on-site and a psychiatrist is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and administer medications as clinically indicated.

› Treatment is focused on stabilization and improvement of functioning and reintegration into the community.

– Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued ambulatory treatment services as needed.

– Treatment at this level of care is not primarily for the purpose of maintaining long-term gains made in an earlier program.

– Residential treatment coverage is not based on a preset number of days.

– The length of a standardized program such as a “30-Day Treatment Program” is not considered as a medically necessary reason for admission and/or continued stay at this level of care.

› Residential treatment is not a substitute for a lack of available supportive living environment(s) in the community.
Exclusions:

There are a wide variety of non-psychiatric programs that provide residential services but are not licensed as Eating Disorder Residential Treatment Facilities, or the equivalent, and that do not meet all the above criteria... A few examples follow:

- **Therapeutic Group Homes:** These are professionally-directed living facilities with psychiatric consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions. **Therapeutic (Boarding) Schools:** The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.

- **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** These programs provide therapeutic alternatives for troubled and struggling individuals, offering experiential learning and personal growth through outdoor and adventure-based programming. However, they do not utilize a multidisciplinary team that includes psychologists, psychiatrists, and licensed therapists who are consistently involved in the care of the individual. These programs nearly universally do not meet standards for certification as eating disorder residential treatment programs or the quality of care standards for medically supervised care provided by licensed mental health professionals. (11)

- **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration within the justice system 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.

- **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

**Admission Considerations for Residential Eating Disorders Treatment:**

Within 72 hours prior to admission, there has been a face-to-face assessment with the individual and family/significant others by a licensed behavioral health professional with training and experience consistent with the age and problems of the individual. This assessment includes a clinically-based recommendation for the need for this level of care.

The admissions process should also include:

- A documented current diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.

- Evaluation by a Board Certified/Board Eligible Psychiatrist with training and experience in the assessment and treatment of eating disorders within 72 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.

- A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.

- Identification of family and/or community resources and family participation in treatment, unless clinically contraindicated or doing so would not be in compliance with existing federal or state laws.

- Discharge planning.
Expectations for Eating Disorders Residential Treatment:

› Residential treatment should occur as close as possible to the home to which the individual will be discharged.
   – If out-of-area placement is unavoidable, there must be consistent family involvement with the individual and regular family therapy and discharge planning sessions, unless clinically contraindicated.

› Within 72 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information

› Family Involvement – The treatment should be family-centered with both the patient and the family included in all aspects of care. Therefore, prompt, timely involvement of family/significant others is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
   – Assessment - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
   – Family therapy should occur at least weekly, unless clinically contraindicated, and should be on a face-to-face basis
     • However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly along with face-to-face family sessions as frequently as possible.
     • Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
   – Discharge planning.

› A Preliminary Treatment Plan is completed within 48 hours of admission and a Comprehensive Treatment Plan is to be completed within 72 hours that includes:
   – A clear focus on the issues leading to the admission and on the symptoms that needs to improve to allow treatment to continue at a less restrictive level of care.
   – Multidisciplinary assessments of behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and the living situation.
   – All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
   – The family in at least weekly therapy or, if the family lives greater than 3 hours from the facility, weekly telephone contact for family therapy must be conducted with face-to-face family therapy sessions as frequently as possible.
   – Realistic, specific, measurable, and achievable goals.
   – This plan should:
     • Be developed jointly with the individual and family/significant others.
     • Include multidisciplinary assessments.
     • Establish measurable goals and objectives.
     • Include treatment modalities that are appropriate to the clinical needs of the patient.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.
Discharge planning will start at the time of admission and include:

– Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.

– Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.

– Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up medical appointment.

Medical Necessity Criteria – Eating Disorders Residential Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.

2. The individual has a documented diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

3. If there are medical issues, they can be safely managed in a residential level of care.

4. For individuals diagnosed with Anorexia Nervosa, the body mass Index (BMI) is greater than 16. Growth charts should be utilized for children and adolescents.

5. Admission to this level of care is determined by:
   A. The severity of physical and psychological symptoms and the level of risk to the individual
   B. Evidence that a less restrictive level of care is not likely to provide safe and effective treatment.

6. Additional considerations include, but are not limited to, one of the following criteria:
   A. Structure and supervision is needed at all meals to prevent restricting or binging-purging and the family/support system is unable to provide this level of monitoring at a less intensive level of care, OR
   B. The individual’s condition requires around the clock intervention to provide interruption of the food restriction, excessive exercise, binging, purging and/or use of laxatives/diet pills/diuretics, to avoid impending life threatening medical consequences or to avoid impending life threatening complications due to a co-morbid medical condition (e.g. pregnancy, uncontrolled diabetes), OR
   C. Along with a primary eating disorder that is requiring active treatment, there is a co-occurring psychiatric disorder or risk of self-harm requiring 24 hour supervision.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Partial Hospitalization for Eating Disorders

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Partial Hospitalization for Eating Disorders provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety with support systems in the community.

› Treatment provided in this setting is similar in nature and intensity as that provided in an inpatient hospital setting. As such, the role of this level of care is to respond to acute situations, which without this level of care, could potentially result in life-threatening emergencies.

› Cigna agrees with the following principles, as stated by the Association for Ambulatory Behavioral Healthcare (AABH):
  – “Partial hospitalization programs (PHP’s) are active, time-limited, ambulatory behavioral health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu.” (7)
  – PHP’s may pursue one or both of the following major functions:
    • Acute Crisis Stabilization
    • Acute Symptom Reduction.

› Partial hospitalization programs may be free-standing, part of a behavioral health organization, or a department within a general medical healthcare system

› An Individual in Partial Hospitalization for Eating Disorders:
  › May present ongoing risk of harm to him/her or others, but is able to develop a plan to maintain safety in the community without 24-hour supervision.
  › Is having acute eating disorder symptoms that are compromising daily functioning with work, parenting, school, and/or with other activities of daily living

› Has the ability:
  – To make age-appropriate basic decisions for him/herself AND
  – To accept age-appropriate responsibility for his/her own actions
Admission Considerations for Partial Hospitalization for Eating Disorders:

› Within 72 hours prior to admission, there has been a face-to-face assessment by a licensed behavioral health professional with training and experience in the assessment and treatment of eating disorders. This assessment includes a clinically-based recommendation for the need for this level of care.

› The admissions process should also include:
  - A documented current diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of significant distress/impairment.
  - Evaluation by a Board Certified/Board Eligible Psychiatrist within 48 hours of admission who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care who also reviews and approves the appropriateness for this level of care and consideration of alternative less restrictive levels of care and who sees the individual as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
  - A medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to admission to the facility was sufficient.
  - Identification of family and/or community resources and family participation in treatment when indicated.

Discharge planning.

Expectations for Partial Hospitalization for Eating Disorders:

› Individuals who are at this level of care:
  - Are typically in a structured treatment program 5 days per week.
  - At a minimum, 20 hours of scheduled programming extended over at least five (5) days per week are to be provided.
  - Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills.
  - Live in the community without the restrictions of a 24-hour supervised setting during non-program hours, other than age appropriate limitations for children and adolescents.
  - Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Intensive Outpatient programs as this is an ambulatory service. However, during non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others, except as age-appropriate for children and adolescents.

› The attending psychiatrist is expected to assess individuals weekly or more frequently as needed.

› During program hours, there is daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist

Family Involvement - Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  - Assessment - The family is needed to provide detailed initial history to clarify and understand the current and past events leading up to the admission.
Family therapy is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.

- **Family therapy** will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

**Discharge planning.**

> An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:

- A focus on the issues leading to the admission.
- Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, living situation.
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
- Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
- Clear, objective and observable discharge criteria.
- A discharge plan that includes coordination with community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

*For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.*

**Note:** The Treatment Plan is not based on a pre-established programmed plan or time frames.

> The Discharge Plan starts at the time of admission and includes:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments within 7 days of discharge date.
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Note:** This level should not be confused with sub-acute “Day Programs” where the focus is on the long-term social rehabilitation and maintenance of individuals with severe and persistent mental illness.

**Medical Necessity Criteria – Partial Hospitalization for Eating Disorders**

**Criteria for Admission**

1. **All of the following must be met:**
   
   A. All elements of Medical Necessity must be met.
   
   B. The individual has a documented primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
C. The individual is mentally and emotionally capable to actively engage in the treatment program and is able to comply with the requirements and structure of a partial hospital program, as demonstrated by ALL of the following:

i) The individual is expressing willingness to engage in treatment.

ii) The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.

iii) The individual has a support system that includes individuals who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

D. Current medical Issues can be safely managed in a partial hospital level of care, AND

2. **One or more of the following must be met:**

   A. The individual is demonstrating significant impairments in functioning secondary to an eating disorder to the extent that:

      i) The individual is not able to complete daily routine social, family, school, and/or work activities, AND

      ii) The individual is not able to employ the necessary coping skills to compensate for this.

   B. The individual requires a structured program to avoid complications of a co-existing medical condition (e.g., pregnancy, uncontrolled diabetes), OR

   C. The individual has recently demonstrated actions of or made serious threats of self-harm or harm to others, but does not require a 24-hour monitoring environment, OR

   3. The individual is mentally and emotionally capable to actively engage in the treatment program

   4. The individual is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.

   5. The individual is expressing willingness to engage in treatment.

   6. The individual and the family are able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.

   7. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR- If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.

**Criteria for Continued Stay**

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. **One or more of the following criteria must be met:**

   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR

   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
Intensive Outpatient Treatment for Eating Disorders

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

Description – Intensive Outpatient Treatment for Eating Disorders provides a coordinated, intense, ambulatory, multi-disciplinary and time limited treatment for individuals who can maintain personal safety w/ support systems in the community and who can maintain some ability to fulfill family, student, or work activities.

› Intensive Outpatient programs may be free standing, part of a behavioral health organization, or a department within a general medical healthcare system.

› An Individual in Intensive Outpatient Treatment for Eating Disorders:
  – Has the ability:
    • To make basic decisions for him/herself AND
    • To accept responsibility for his/her own actions and behavior,
  – Is experiencing psychosocial stressors and/or complex family dysfunction, such that a multi-disciplinary treatment team is needed to stabilize the individual.
  – Is not at imminent risk for serious bodily harm toward self or others.
  – Is appropriate to consider for complex clinical situations that would otherwise result in the need for a more restrictive level of care
  – Clinical interventions may include individual, couple, family, and group psychotherapies along with medication management.
  – This level of care can be the first level of care authorized to generate new coping skills, or can follow a more intensive level of care to reinforce acquired skills that might be lost if the participant immediately returned to a less structured outpatient setting.

Note: Low Intensity Outpatient Programs and Aftercare Services are sometimes offered by facilities that provide an intermediate step between Intensive Outpatient Treatment and routine Outpatient care. These programs are reviewed as group therapy, utilizing the guidelines for Outpatient Treatment.
Admission Considerations for Intensive Outpatient Treatment for Eating Disorders:

› Prior to admission, there has been a face-to-face individual assessment with the individual and the family/significant others by a licensed behavioral health clinician, with experience in Eating Disorders, to determine if this is a level of care that is medically necessary and clinically appropriate.

› Alternative less restrictive levels of care are considered and referrals are attempted as appropriate.

Expectations for Intensive Outpatient Treatment for Eating Disorders:

› Individuals who are at this level of care:
  – Are typically in a structured treatment program 3-4 hours per day, 3-5 days per week.
  – Will have the opportunity to be exposed to circumstances/stressors that may have contributed to the admission and practice their coping skills
  – Live in the community without the restrictions of a 24-hour supervised setting during non-program hours
  – Are capable of safely controlling their behavior and seeking professional assistance or other support as needed.

› Cigna does not cover boarding for Intensive Outpatient programs as this is an ambulatory service. However, during non-program hours, an individual who is boarding at or near a facility must have the freedom to interact with the community independently, without being accompanied by staff or others.

› The facility provides a structured program, which is staffed by behavioral health professionals who are trained and experienced in the treatment of eating disorders.

› A psychiatrist is available for consultation, as needed.

› An Individualized Treatment Plan is completed within 24 hours of admission. This plan includes:
  – A focus on the issues leading to the admission.
  – Assessment of psychiatric and behavioral issues, substance abuse, medical illness(s), personality traits, social supports, education, and living situation.
  – All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
  – The treatment plan results in interventions utilizing medication management, individual, group, marital and family therapies as appropriate.
  – Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
  – Clear, objective and observable discharge criteria.
  – A discharge plan that includes coordination with family and community resources to allow a smooth transition back to outpatient services, family integration, and continuation of the recovery process.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

Note: The Treatment Plan is not based on a pre-established programmed plan or time frames.

› Family Involvement – Prompt family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
- **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.

- **Family therapy** is relevant to the treatment plan and will occur at a level of frequency and intensity needed to achieve the treatment goals.
  
  - Family therapy will occur in a **face-to-face setting** (Note: Telephonic conferences are not considered a substitute. Exceptions must be reviewed and a decision to approve telephonic conference(s) should be made on a clinical basis.)

- **Discharge planning.**

  - **A Discharge Plan** that starts at the time of admission and includes:
    
    - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
    - Timely and clinically appropriate aftercare appointments
    - A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

**Medical Necessity Criteria – Intensive Outpatient Treatment for Eating Disorders**

**Criteria for Admission**

**All of the following must be met**

1. All elements of Medical Necessity must be met.

2. The individual has a documented primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders,

3. Current medical issues can be safely managed in an intensive outpatient level of care

4. The individual is demonstrating difficulties in functioning secondary to an eating disorder to the extent that:
   
   A. The individual has demonstrated an inability to maintain a healthy weight and/or medical stability without frequent structured interventions of greater intensity/frequency than in routine outpatient treatment for eating disorders, OR

   B. The individual has documented evidence of repeated relapses, and inability to carry out treatment plan objectives in routine outpatient treatment for eating disorders. OR

   C. The individual cannot reduce incidents of purging in an unstructured setting. The individual requires some degree of structure for eating full meals and gaining weight but not as much as typically provided in a partial hospitalization program.

5. The individual is mentally and emotionally capable to actively engage in the treatment program.

6. The individual is able to live in the community without the restrictions of a 24-hour supervised setting, except as age-appropriate for children and adolescents.

7. The individual is able to develop a safety plan with the provider that includes being able to access emergency services so that a more intensive level of care is not required.

8. The individual has a support system that includes family or significant others who are able to actively participate in treatment – OR – If the individual has no primary support system, the individual has the skills to develop supports and/or become involved in a self-help support system.
Criteria for Continued Stay

All of the following must be met

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:
   
   A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR
   
   B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR
   
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:
   
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   
   C. Continued stay is not primarily due to a lack of external supports.
**Crisis Stabilization**

**Standards and Guidelines**

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;

› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and

› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.


**Description – 23-Hour Crisis Stabilization/Observation** provides evaluation and intervention for individuals with acute symptoms of a behavioral health disorder when the clinical presentation does not immediately indicate the need for a higher level of care. It is considered when an individual presents with:

› Acute symptoms of mental illness

› Impairments caused by abuse of substances.

› Behavior problems of a serious magnitude which cause immediate interference with the individual’s ability to function at work, in school, within the family, or in social interactions.

**Settings where service can be provided include:**

› **A hospital** – only when the facility is able to provide this service for no more than 23 hours.

› **A Licensed Crisis Intervention Center** (either free-standing or attached to a hospital) that is able to provide the service for no more than 23 hours.

› An outpatient clinical setting.

The ultimate setting is determined by the individual’s clinical presentation, available resources, and by the facility’s ability to begin active interventions within six hours of presentation.

**Focus of the intervention:**

› Psychosocial factors relevant to the crisis.

› Assessment for risk of harm to self or others.

› Assessment of support networks.

› A complete medical evaluation and basic medical procedures as indicated.

› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

› Identification and mobilization of other available services.

› Evaluation of the individual’s willingness and reliability to participate in a mutually-acceptable treatment plan.
Note: This level of care is not appropriate when, based on clinical presentation or history, there is a strong likelihood that the individual will need the intensive structure of Acute Inpatient Treatment for more than 23 hours.

Description – Crisis Stabilization Unit (greater than 23 hours):

The use of Crisis Stabilization Unit (greater than 23 hours) is likely to be infrequent, but may apply in those cases where a Crisis Stabilization Unit exists outside of an accredited hospital, but where 24-hour supervised and medically monitored services are available.

This service provides:

› The same type and intensity as a Crisis Stabilization Program offering intervention for 23 or less, but where 24-hour supervised and medically monitored services are available for those hours individuals needing:
  – Longer periods of observation to assess the crisis and determine risk.
  – Safe environment for more than 23 hours.
  – Psychiatric consultation – to occur ideally as soon as possible following admission, but definitely prior to discharge.
  – A complete medical evaluation and basic medical procedures as indicated.
  – Evaluation of family and social support systems that identify both opportunities and challenges, and a plan to address the latter.
  – Linkage and referrals to long-term services/community services.

› When medical services are not available on site, the program must be able to ensure that the individual will be linked to appropriate treatment and providers within a reasonable timeframe.

Focus of the Intervention

The goals of the intervention at this level of care are similar to the goals of a 23 hour-or less Crisis Stabilization program and include similar criteria:

› Reduction of potential for harm to self or others and reduction of symptoms due to psychosis or substance use.

› Ability to begin active interventions within 6 hours of admission by a mental health professional

› Identification and mobilization of available resources including support networks

› The crisis stabilization intervention should focus on factors relevant to the crisis.

› Appropriate Interventions include assessment of support networks, identification and assessment of available services, mobilization of those services, and an estimate of the individual's ability to access services and participate in the treatment plan.

Note: This level of care is not appropriate for an individual who, by clinical presentation or history, requires the intensive structure of Acute Inpatient Treatment for safely and stabilization.

The facility setting for a crisis stabilization bed, whether less than or greater than 23-hours, is within a unit that provides around-the-clock nursing and/or mental health staff supervision and continuous observation and control of behaviors to insure the safety of the individual and/or others.

Description – Outpatient Crisis Stabilization:

Outpatient Crisis Stabilization occurs as an ambulatory session. The services provided are rapid with immediate evaluation and triage to avoid further decrease in level of functioning and/or acute hospitalization. The services are intensified as needed and are available 24 hours a day, seven days per week.
This service provides:

› Assessments to determine risk of harm to self or others and/or determine need for secure environment.
› Evaluation for medical emergency and ability to safely transport to medical facility if necessary.
› Intervention in any one of a number of settings including outpatient therapy office, facility-based outpatient department, or in the home of an individual with safety of all parties a primary concern.

Focus of the Intervention

› Psychosocial factors relevant to the crisis.
› Assessment for risk of harm to self or others.
› Assessment of support networks.
› Identification and mobilization of other available services.
› Evaluation of the individual’s willingness and reliability to access and participate in a mutually-acceptable treatment plan.
› Development of a short-term, evidence-based treatment plan than includes a family or support system evaluation or therapy session.
› Plan for follow-up that includes collaboration with family, the individual’s psychiatrist, other mental health providers, the individual’s primary care physician, and/or other community resources as appropriate.

Note: This level of care does not include crisis stabilization services provided within an emergency room setting. Emergency Room services are generally covered by an individual’s health plan benefits.

Medical Necessity Criteria – Crisis Stabilization

Criteria for Admission

All of the following must be met:

1. All elements of medical necessity must be met.
2. **One or more of the following criteria must be met:**
   A. The individual is expressing suicidal ideation, and/or hopelessness and helplessness likely to lead to self-injury, which must continue to be evaluated for severity and lethality. Because of lack of more immediately available support systems, this cannot be evaluated in a less restrictive setting, OR
   B. The individual is threatening harm to others or has acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation. This evaluation includes attempting to discern the etiology of such behaviors, especially if suspected to be chemically or organically induced, OR
   C. The individual is presenting with significant emotional and/or thought process disturbances which interfere with his/her judgment so as to seriously endanger the individual if not evaluated and stabilized on an emergency basis, OR
   D. The individual is showing severe signs of an acute stress reaction to a recent destabilizing event that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment. In addition, there is a need for a time-limited intervention to allow time for mobilization of additional resources and supports, OR
E. The individual is in current treatment but the nature of the individual’s course of illness is one characterized with recurrent presentations of self-injury or impaired thinking that responds rapidly to structured interventions. This level of care should only be considered when support systems and/or the previously designed crisis plan of the individual and his/her therapist have not been sufficient and the likelihood for further deterioration is high, OR

F. The individual is presenting with intoxication that causes significant emotional, behavioral, medical, or thought process disturbance that interfere with his/her judgment so as to seriously endanger the individual if not monitored and evaluated for the need of ambulatory or inpatient detoxification.

Criteria for Continued Stay in Crisis Stabilization Unit (greater than 23 hours):

All of the following must be met:

1. The individual continues to meet all elements of medical necessity.

2. One or more of the following criteria must be met:

   A. The treatment provided is leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, OR

   B. If the treatment plan implemented is not leading to measurable clinical improvements in symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan, when clinically indicated, OR

   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.

   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

   C. Continued stay is not primarily due to a lack of external supports.
Electroconvulsive Therapy (ECT)

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: [link](http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions).

Description – Electroconvulsive Therapy (ECT)

› ECT is most often used to treat severe depression that fails to respond to medications or for individuals who are unable to tolerate the side effects associated with the medications.
› ECT may be the treatment of choice – When there is a need for rapid stabilization for individuals who are at acute risk of harm due to severe agitation, delusions, suicidality, not eating or drinking. OR
› For individuals with acute catatonia (a potentially life threatening trance-like state). OR
› For stabilization of bipolar illness during extreme episodes of mania or depression and
› To halt psychotic episodes associated with schizophrenia.

Note: This treatment may be administered on either an outpatient or inpatient basis.

Treatment Considerations for Electroconvulsive Therapy (ECT):

› The severity of the psychiatric illness requires a rapid, definitive response.
› The risk of ECT is less than the risks of other treatments.
› There is a history of good response to ECT or poor response to medication in previous episodes of illness; or
› The individual or legal representative, having discussed all alternative treatments, and being aware of and able to comprehend the risks and potential benefits of ECT, chooses ECT as his or her preferred treatment.
› If the individual receiving ECT has a severe psychiatric illness that requires Acute Psychiatric Hospitalization, the individual may then continue this treatment on an outpatient basis once stabilized to a point that 24-hour inpatient care is no longer a medical necessity.
› Inpatient hospitalization may also be indicated for the initial few treatments for individuals with co-existing medical conditions that may seriously increase the risk of the procedure.
› For most individuals, ECT is generally safe and effective on an outpatient basis when there is no medical necessity for more restrictive levels of care.
Expectations for Electroconvulsive Therapy (ECT):
The initiation of ECT is preceded by certain assessments and procedures:

› A psychiatric evaluation that establishes that the diagnostic criteria are met for a condition that evidence has shown to be likely to positively respond to ECT.

› A medical assessment to evaluate for any medical conditions that might increase the risks associated with ECT or anesthesia, as well as an evaluation by a qualified nurse anesthetist or anesthesiologist to determine if there are any conditions that may indicate a need for special precautions.

› All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

› Education of the individual and family about the procedure that includes disclosure of potential risks and benefits and that results in written, informed consent by the individual or legal guardian, with the understanding that such consent may be withdrawn at any time.

› The ECT procedure is administered by a psychiatrist who has participated in ongoing continuing education on ECT and who maintains all legally-required certifications.

› An assessment of currently prescribed medications has been completed, and if the individual is continuing to take certain medications that might possibly negatively impact the procedure (e.g., theophylline, lithium, benzodiazepines, and/or anticonvulsants), there is documentation of the clinical reasons for continuation of these medications.

Note: If there is evidence of any of the following medical conditions, there needs to be documented evidence that the risks and benefits of ECT vs. other forms of treatment vs. no further treatment have been thoroughly considered and reviewed with the individual or guardian, and that the individual's condition requires a rapid, definitive response:

› Unstable or severe cardiovascular disease

› Aneurysm or arteriovenous malformation

› Recent stroke

› Severe lung disease

› American Society of Anesthesiology physical status classification level Four or Five.

Medical Necessity Criteria – Electroconvulsive Therapy (ECT)

Criteria for Initiation of Treatment

All of the following must be met:

1. All elements of medical necessity must be met.

2. One or more of the following criteria must be met:

   A. The individual has a diagnosis of Major Depression, moderate or severe, or Mania, AND

      i) Is resistant to treatment with medications, as evidenced by a lack of response to trials of at least three medications with adequate dose, duration and compliance to meet an expectation of improvement, OR

      ii) Is intolerant of the side effects or adverse effects of psychopharmacologic agents, or is unable to take such agents due to drug interactions with a medically necessary medication deemed to be less likely or less severe with ECT, OR

      iii) Experiences deterioration of a psychiatric condition that creates a need for a rapid, definitive response to ensure the safety of the individual, OR
iv) Is experiencing a high degree of symptom severity and functional impairment.

OR

v) Has a history of favorable response to ECT

B. The individual has a diagnosis of a psychotic disorder with (one of the following):
   i) Abrupt or recent onset of psychotic symptoms, OR
   ii) Catatonia, OR
   iii) A history of favorable response to ECT, OR
   iv) Experiences deterioration of a psychiatric condition that creates a need for a rapid, definitive response to ensure the safety of the individual, OR
   v) Is experiencing a high degree of symptom severity and functional impairment.

3. All of the following must be met:
   A. A medical evaluation has been completed to assess potential risks associated with ECT.
   B. Risks and potential benefits of ECT have been explained and understood by the individual or guardian, and written, signed, informed consent has been obtained.
   C. Where applicable state laws require it, a second opinion consultation has been completed. Second opinion consultations should also be considered for women who are pregnant or for children/adolescents under age 18.
   D. There is no evidence of increased intracranial pressure (most commonly due to an inflammatory condition in or around the brain or spinal cord).

Criteria for Continued Treatment Course of Electroconvulsive Therapy

1. All of the following must be met:
   A. The initial course of treatment consists of two to three treatments per week, generally on non-consecutive days. (Note: the frequency of treatments may be reduced if delirium or severe cognitive dysfunction occurs).
   B. The number of treatments is a function of the individual’s response, but should be in the range of 6 to 12 but not to exceed 20 sessions.
   C. If there is no clinical improvement after 8-10 sessions, the potential benefits of continued ECT should be reassessed by the Attending Physician.

2. Continuation ECT (continuation of treatment for 6 months at intervals of 1 week or longer) is indicated if both of the following are met:
   A. The individual has responded well to ECT.
   B. Interval psychiatric and medical evaluations are completed prior to each treatment,
   C. Frequency of sessions is at the minimum which sustains remission.
   D. Continued need for Continuation ECT is reassessed every month.
   E. Clinical treatment plans and consents are updated every month.
3. **Maintenance ECT** (continuation of treatment for longer than 6 months at intervals of 2 weeks or longer) is indicated if all of the following are met:

   A. The individual has responded well to ECT.
   B. Interval psychiatric and medical evaluations are completed prior to each treatment.
   C. Frequency of sessions is at the minimum which sustains remission.
   D. Continued need for Maintenance ECT is reassessed every six months.
   E. Clinical treatment plans and consents are updated every six months.
Psychological/Neuropsychological Testing

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;
› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:

Description – Psychological/Neuropsychological Testing is the use of one or more standardized measurements, instruments or procedures to assess intellectual/cognitive ability, psychopathology, psychiatric symptomatology, personality, interpersonal processes, behavioral functioning, and/or adaptive skills.

› May be used to guide differential diagnosis in the treatment of psychiatric disorders and to provide treatment recommendations.
› The use of validated psychological testing instruments is considered adjunctive to other assessment tools that may include a face-to-face clinical interview, information gathering and review use of behavioral rating scales, consultation with collateral sources, and the individual’s history.
› Psychological testing may be an appropriate adjunctive intervention when its use is expected to have a unique, specific, and direct impact on treatment outcome.

Exclusion:

› Educational testing is not considered a medically necessary service under the behavioral health benefits.
  – Educational testing is the use of psychological tests for educational purposes (e.g., to rule out a learning disability, determine learning style, and/or assess academic achievement), to provide support for an academic accommodations request, or for vocational purposes.
  – Parents of children looking for educational testing are encouraged to check with their public school district for resources.

Psychological Testing In Alcohol and Drug Treatment

The individual’s compromised cognitive functioning often confounds the results of psychological testing in the context of early treatment for alcohol and drug dependence. Therefore, there should be a minimum of 30 days abstinence prior to the administration of testing for a mood disorder, and a minimum of 90 days abstinence for the assessment of cognitive functioning/impairment.
Expectations for Psychological/Neuropsychological Testing:

› Psychological testing is to be conducted by a licensed psychologist (Ph.D., Psy.D. or Ed.D.).

› Neuropsychological testing is to be conducted by a licensed doctoral level psychologist (Ph.D. or Psy.D.) who has specialized training in the administration, scoring, and interpretation of neuropsychological instruments.

› Testing by a psychometrist is allowed when the psychometrist has received appropriate training and is working under the direct supervision of a licensed psychologist/neuropsychologist.

› When a psychometrist/psychological assistant are used, the psychologist/neuropsychologist must conduct the clinical interview and design the test battery before the psychometrist begins to administer any tests.

› When administration of psychological/neuropsychological testing is delegated to a psychometrist or psychological assistant, the report must be signed by the fully licensed psychologist or neuropsychologist who is responsible for the interpretation of test results.

**Note:** Psychological testing results for inpatient cases should be reported (at least informally) within 24 hours and for outpatient cases should be reported within one week.

**Medical Necessity Criteria – Psychological/Neuropsychological Testing**

**All of the following must be met:**

1. Psychological/Neuropsychological Testing may be clinically appropriate when the administration of such testing is expected to offer unique, specific and direct information regarding the development or monitoring of the treatment plan.

2. **One or more of the following criteria must be met:**
   
   A. A diagnosis cannot be made with information derived from a thorough clinical interview, behavioral observation, consultation with collateral sources of information, and a review of history, OR
   
   B. Development of a treatment plan would be ineffective and/or inefficient without information that can only be obtained by psychological testing, OR
   
   C. The individual has undergone a course of psychological or psychiatric treatment and the response is not as expected from the treatment plan, OR
   
   D. To assist with the differential diagnosis of a psychiatric versus neurological or other medical diagnosis that may be associated with psychiatric symptoms.

**Psychological/Neuropsychological Testing is generally NOT considered medically necessary when one (or more) of the following are present:**

1. Other sources of the same information are available (e.g., clinical interview, behavioral observations or review of individual’s history), OR

2. The diagnosis appears clear without testing (testing is not required to “validate” a diagnosis), OR

3. The results of testing would have no significant effect on the design and implementation of a treatment plan for a psychological disorder, OR

4. A diagnosis has already been rendered, and the individual has shown improvement via the treatment plan already in place. (e.g., individual’s MD is currently prescribing medication for ADHD but wants testing to “validate” the diagnosis), OR

5. The rationale for testing is vague, or the diagnostic question lacks specificity (e.g., “Parents want to know what’s going on,” “The pediatrician is asking for it,” “Just want to get a bigger picture.”), OR
6. Testing appears to be primarily for educational purposes (e.g., to rule out a learning disability, determine learning style and/or assess academic achievement), to provide support for an academic "accommodations" request, or for vocational purposes, OR

7. The individual has a history of problematic drug or alcohol use/dependence and has not been able to demonstrate a sustained period of sobriety for 30 days prior to testing for a mood disorder/90 days when assessing cognitive functioning, OR

8. Testing is requested primarily for legal purposes including custody evaluations, parenting assessments, or other court or government ordered/requested testing AND the request does not otherwise meet the criteria for testing, OR

9. Testing is requested primarily for work-related concerns/return to work AND the request does not otherwise meet the criteria for testing, OR

10. Results of testing are used primarily for admission to a treatment facility AND the individual would not otherwise meet criteria for testing, OR

11. The requested test battery would not answer the referral question, OR

12. There is concern about the specific tests being requested:
   A. The requested tests are outdated, OR
   B. The reliability and validity for the requested tests are not established, OR
   C. Appropriate normative data are not available for the requested tests.

Notes:

- Psychological/neuropsychological testing may be managed by Cigna Behavioral Health, Cigna Health Care, OR the individual’s medical carrier (Refer to Mixed Services Protocol).

- Employer group requirements may vary regarding preauthorization and review for psychological and neuropsychological testing. Need to confirm the employer group requirements prior to rendering services.

- Cigna Coverage position #0258 Neuropsychological Testing clarifies diagnoses for which Cigna considers neuropsychological testing to be experimental, Investigational or unproven.
Autism Behavioral Intervention Therapies (ABIT)

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;

› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at: http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Note: Autism Behavioral Intervention Therapies (also described as Early Intensive Behavioral Therapies) are excluded under many CIGNA Behavioral Health benefit plans, but may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage (Plans that do not have wording for ABIT will follow Cigna's Coverage Position for therapy type). CIGNA's Coverage Position should be referenced for individual intervention (such as Applied Behavioral Analysis) to treat Autism Spectrum Disorder.

Description – Autism Behavioral Intervention Therapies (ABIT):

Autism Spectrum Disorder causes serious, lifelong impairments in behavior, cognition, and social development. Etiology is heterogeneous and there is no known cure. Early identification and implementation of intensive behavioral interventions have, in many cases, been known to enhance behavioral and cognitive deficits interfering with the typical developmental process. The purpose of intensive behavioral intervention is four-fold:

› Identify current behaviors interfering with typical developmental processes

› Modify interfering behaviors by altering relationships between behavior and the environment

› Improve individuals’ functional capacity in:
  – Communication
  – Development of social relationships

› Reduce maladaptive behaviors that:
  – Are repetitive, restricted and/or stereotypic
  – Interfere with skills and activities of daily living

Expectations for Autism Behavioral Intervention Therapies (ABIT):

The Treatment Assessment

› Initiating an assessment for intensive behavioral intervention requires a review of the following:
  – Diagnosis of an Autism Spectrum Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
– Assessment of current functioning completed by developmental pediatrician, pediatric neurologist, psychologist, psychiatrist, or other independently licensed mental health professional using standardized assessment tools such as the VB-MAPP, Vineland Adaptive Scales, ABLLS, etc.

– Name and credentials of independently licensed mental health professional or Board Certified Behavioral Analyst performing assessment.

During the Assessment a complete developmental history should be conducted. History should include the following, as applicable:

– Pre/post-natal events (e.g., length of gestation, maternal alcohol or drug use; maternal illness, low Apgar scores, etc.)

– Accidents, illnesses or injuries (e.g., head trauma, broken bones, known exposure to toxins, respiratory problems, etc.)

– Known medical syndromes or genetic anomalies (Down’s syndrome, Fragile X, Klinefelter’s Syndrome, Tuberous Sclerosis, seizures, palsies or dystrophies, etc.)

– Developmental milestones in speech and language, fine and gross motor, etc.

– Vision and hearing screenings

– Constellation of family members including parents or caregivers understanding of Autism Spectrum Disorder

All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.

The Intervention Plan

Results of the assessment determine the intervention plan which must include:

– **A clearly stated recommendation** for Autism Behavioral Intervention Therapies (ABIT), including number of hours per day/week for individual to demonstrate functional improvement

Providers with the following Qualifications

– Supervisor – must be a Board Certified Behavior Analyst (BCBA, BCBA-D) or an independently licensed mental health professional

– Treatment Planning – must be provided by a Board Certified Behavior Analyst (BCBA, BCBA-D) or an independently licensed mental health professional

– Behavioral Clinician (responsible for 1:1 work with child) – BCBA, Board Certified Assistant Behavior Analyst (BCaBA), Registered Behavioral Technician, independently licensed mental health clinician and/ or behavioral technician with specific behavioral training.

**Behavioral Targets**

– Baseline data on all behaviors identified for intervention

– Expected improvement over baseline;
  - After the first six months, improvement is expected to be realistic with regard to initial gains in each domain

– Methods to ensure generalization in multiple environments

– Number of hours requested to meet targets

**Parent/Caregiver Participation**

– Method of training parents in behavioral intervention strategies
– Parent/Caregiver goals designed to assist caregiver in implementing the treatment plan and behavioral interventions independently in the home and community
  • Goals should be designed to transition treatment to parents/caregivers upon discharge
– Plan for ensuring consistency of parent/caregiver response over time

› Supervision
  – Assesses quality of the program delivery, monitors progress, identifies barriers to progress and initiates changes where needed
  – Ensures effective collaboration between the treatment team and parent(s)/caregivers
  – Occurs at the rate of 1 hour for every 10 hours of 1:1 treatment time

› Treatment Planning
  – Supervisor is responsible for provision of Treatment Planning
  – Treatment Planning should be used to continuously develop intervention plan and note individual progress.

› Place of Service
  – Direct Service can be center-based, home based, or community based (must be consistent with realistic treatment goals).
  – Cannot take the place of mandated educational services provided to an individual through state or federal legislation
    • Although placement in a private educational institution is a parental right, it does not preclude the state from its mandated responsibilities

› Transition and/or Discharge Criteria

Medical Necessity Criteria – Autism Behavioral Intervention Therapies (ABIT)

Criteria for Initiation of Treatment with ABIT

All of the following must be met:

1. All elements of medical necessity must be met.
2. Diagnosis of an Autism Spectrum Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders,
3. A full and comprehensive evaluation as noted above has been completed.
4. There is evidence from the evaluation that suggests the individual is capable of making behavioral and cognitive gains.
5. There is a comprehensive and individualized behavioral treatment plan that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improving those behaviors.
6. Treatment does not replace or interfere with educational services, if applicable.
7. The treatment plan includes a plan for the individual's parents to continue behavioral interventions in the home environment.
Criteria for Continued Treatment

All of the following must be met:

1. The individual continues to meet all elements of medical necessity
2. Treatment continues to follow expectations for ABIT services as detailed above
3. The individual's treatment plan has been updated to include addressing new behaviors and ensuring maintenance of acquired skills
4. The individual's caregivers continue to have active participation and are showing proficiency towards parent/caregiver goals as prescribed by the treatment plan
5. There is evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of a reliable and valid assessment instrument (e.g., ABLLS, VB-MAPP)
6. The treatment program is coordinated with government mandated/school services and other medical and mental health therapies, as appropriate
7. Documentation of plan for transition, fade plan, and discharge criteria for services
Medication Assisted Treatment (MAT) for Opioid Dependence

Standards and Guidelines

**Medical Necessity** – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

› In accordance with the generally accepted standards of medical practice;

› Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and

› Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.


**Description – Medication Assisted Treatment (MAT) for Opioid Dependence** is an approved standard of practice for maintenance, detoxification and medically supervised withdrawal.

› There are currently two medications that are available and approved for use in opioid maintenance treatment: methadone and sublingual formulations of buprenorphine.

› Opioid maintenance treatment can offer pharmacologic benefits that help to support an individual’s efforts to achieve and sustain abstinence. It also can help with retention in treatment, so that medical and psychosocial issues may be addressed.

**Admission Considerations for Medication Assisted Treatment (MAT) for Opioid Dependence:**

› This level of care should be considered only after a complete substance abuse assessment, and consideration of all available alternative levels of care.

› At times, MAT may also be utilized as part of a comprehensive program that includes substance abuse treatment at other levels of care as well.

**Note:** Methadone maintenance treatment is explicitly excluded under many CIGNA Behavioral Health benefit plans, and may be governed by federal and/or state mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

**Expectations for Medication Assisted Treatment (MAT) for Opioid Dependence:**

› Medication Assisted Treatment (MAT) for Opioid Dependence is limited to providers or programs that have the appropriate DEA certifications and meet all legally mandated requirements.
Medical Necessity Criteria – Medication Assisted Treatment (MAT) for Opioid Dependence

Criteria for Initiation of Treatment

All of the following must be met:

1. All elements of medical necessity must be met.
2. The individual has a diagnosis of opiate dependence.
3. One or more of the following criteria must be met:
   A. The individual has a one-year history of dependence on opiates, OR
   B. The individual is currently pregnant.
4. All of the following must be met:
   A. The individual is willing to adhere to treatment plans and recommendations.
   B. The individual is actively engaged in treatment, which may include on-site or community-based outpatient individual, group, or family treatment, or IOP, or PHP.
   C. The individual has an understanding of the need for compliance with medication dosages.
   D. The individual has a supportive and consistent recovery environment.
   E. If under 18, the individual’s parental consent is obtained.
   F. The individual does not meet any of the following exclusion criteria as defined below:

Exclusion Criteria:

1. The individual has the presence of active suicidal thoughts.
2. The individual has active alcohol abuse or dependence without engagement in an active treatment plan.
3. The individual has mental illness that would interfere with compliance or adherence to treatment protocols.
4. The individual has a history of prior adverse reactions to MAT.
5. The individual has a severe medical illness that makes dosing unsafe.
6. The individual is abusing/obtaining opiates from other sources or diverting medication to others, and/or unwilling to participate in treatment plan changes.

Note: For medication-assisted treatment, methadone maintenance is considered the treatment of choice in pregnant women, although buprenorphine may also be useful in selected cases

Criteria for Continuation of Treatment

All of the following must be met:

1. The individual's MAT medication dose is safe and adequate.
2. The individual is compliant with attendance and dosing plans.
3. The individual remains willing to follow through with treatment plans and recommendations.
4. The individual has a supportive and consistent recovery environment.
5. Routine, periodic drug screening results are negative, or if positive, have led to treatment plan changes.
Voluntary Tapering and Discontinuation:

All of the following must be met:

1. The individual has a consistent and supportive recovery environment.
2. The individual is actively involved in a relapse prevention program.
3. The individual has the necessary support systems in place to make a long-term treatment commitment: i.e. transportation, support groups as well as familial or social contacts.
References


6) Preauthorization Requirements for Residential Treatment Center Care, TRICARE Policy Manual 6010.54-M, August 1, 2002, Chapter 7, Section 3.4. State Regulation of Residential Facilities for Adults with Mental Illness, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, www.samhsa.gov


9) Outpatient Hospital Psychiatric Services, Medicare Benefit Policy Manual, Chapter 6, Section 70 - Hospital Services Covered Under Part B, A3-3112.7, HO-230.5 (Rev. 157, 06-08-12)

10) Medicare Hospital Manual, Section 230.7, Outpatient Partial Hospitalization Programs (PHP), Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), 2000


12) TRICARE/CHAMPUS standards for Residential Treatment Centers (RTCs) Serving Children and Adolescents, TRICARE Reimbursement Manual 6010.55-M, August 1, 2002, Chapter 7, Addendum H.


http://www.ncbi.nlm.nih.gov/books/NBK64245/

v) Brief Interventions and Brief Therapies for Substance Abuse. (Treatment Improvement 
vi) http://www.ncbi.nlm.nih.gov/books/NBK64947/

17) Practice Guidelines for the Treatment of Psychiatric Disorders, Treatment of Patients with Eating 


19) American Academy of Family Physicians, Diagnosis of Eating Disorder in Primary Care, Table 6, 

on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents 

21) Practice Parameter for Use of Electroconvulsive Therapy with Adolescents, AACAP Official Action, 

22) Sachs, M. and Madaan, V., Electroconvulsive Therapy in Children and Adolescents: Brief Overview 
and Ethical Issues, Sponsored by AACAP Ethics Committee, January, 2012.
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Cigna Behavioral Health
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Cigna Behavioral Health
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Cigna Behavioral Health
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Appeals Clinician
Cigna Behavioral Health
Plano, TX

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Lutherville, MD

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Cigna Behavioral Health
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