Health Share of Oregon

Pathways Regional Practice Guidelines

Regional Behavioral Health Guidelines for Clackamas, Multnomah and Washington Counties

A Manual for Utilization Review Staff and Health Share of Oregon Providers

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Introduction

Medicaid managed care organizations are required to adopt practice guidelines that are based on valid and reliable clinical evidence, consider the needs of our individuals, and are adopted in consultation with our participating providers. Decisions for utilization management and coverage of services should be consistent with these guidelines.

Health Share of Oregon-along with the Behavioral Health Plan Partners (BHPPs)-Clackamas, Multnomah and Washington County has adopted a definition of medical necessity criteria and a set of practice guidelines as a resource for both providers and our staff. It should be noted that these guidelines are administrative in nature; they are not clinical practice guidelines. Clinical practice guidelines reflect practice standards for the management and treatment of specific conditions .Administrative guidelines describe the criteria for authorization for specific types of service.

The primary purpose of these guidelines is to assist providers in selecting the appropriate level of care for clients, and to inform providers of the criteria used by the BHPPs in authorizing services.

Practice Guidelines – Values and Principles

Values:

Health Share of Oregon promotes resilience in and recovery of its members. We support a system of care that promotes and sustains a person's recovery from a mental health condition by identifying and building upon the strengths and competencies within the Individual to assist them in achieving a meaningful life within their community.

Individuals are to be served in the most normative, least restrictive, least intrusive, and most cost-effective level of care appropriate to their diagnosis and current symptoms, degree of impairment, level of functioning, treatment history, individual voice and choice, and extent of family and community supports.

Practice guidelines are intended to assure appropriate and consistent utilization of mental health services and to provide a frame of reference for clinicians in providing services to individuals enrolled in Health Share of Oregon. They provide a best practice approach and are not intended to be definitive or exhaustive.

When multiple providers are involved in the care of our members, it is our expectation that regular coordination and communication occurs between these providers to ensure coordination of care. This could include sharing of service plans, joint session, phone calls or team meetings.

Principles:

1. Treatment planning incorporates the principles of resilience and recovery:
   - Employs strengths-based assessment
   - Individualized and person-centered
   - Promotes access and engagement
   - Encourages family participation
   - Supports continuity of care
   - Empowering
   - Respects the rights of the individual

- Involves individual responsibility and hope in achieving and sustaining recovery
- Uses natural supports as the norm rather than the exception

2. Policies governing service delivery are age and gender appropriate, culturally competent, evidence-based and trauma-informed, attend to other factors known to impact individuals' resilience and recovery, and align with the individual's readiness for change. With the goal of the individual receiving all services that are clinically indicated. --- Ensuring that individuals have access to services that are clinically indicated.

3. Positive clinical outcomes are more likely when clinicians use evidence based practices or best clinical practices based on a body of research and as established by professional organizations.

4. Treatment interventions should promote resilience and recovery as evidenced by:
    - Maximized quality of life for individuals and families
    - Success in work and/or school
    - Improved mental health status and functioning
    - Successful social relationships
    - Meaningful participation in the community

Medical Necessity Criteria

All services provided to Oregon Health Plan Medicaid recipients must be medically appropriate and medically necessary. For all services, the individual must have a diagnosis covered by the Oregon Health Plan which is the focus of treatment, and the presenting diagnosis and proposed treatment must qualify as a covered condition-treatment pair on the Prioritized List of Health Services.

Medically appropriate services are those services which are:

- Required for prevention, diagnosis or treatment of physical, substance use or mental disorders and which are appropriate and consistent with the diagnosis
- Consistent with treating the symptoms of an illness or treatment of a physical, substance use or mental disorder
- Appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective
- Furnished in a manner not primarily intended for the convenience of the individual, the individual's caregiver, or the provider
- Most cost effective of the alternative levels of covered services which can be safely and effectively furnished to the individual

A covered service is considered medically necessary if it will do, or is reasonably expected to do, one or more of the following:

- Arrive at a correct diagnosis
- Reduce, correct, or ameliorate the physical, substance, mental, developmental, or behavioral effects of a covered condition
- Assist the individual to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities, and/or maintain or increase the functional level of the individual
- Flexible wraparound services should be considered medically necessary when they are part of a treatment plan.

The determination of medical necessity must be made on an individual basis and must consider the functional capacity of the individual and available research findings, health care practice guidelines, and standards issued by professionally recognized organizations.

Self-Authorized Service Notification Required

Level A – C Outpatient MH Services – Adult
Level B SPMI; and Level C SPMI Outpatient MH Services - Adult
Level A – C Outpatient MH Services – Youth
Substance Use Disorder Outpatient Services – Adult
Substance Use Disorder Outpatient Services - Youth
Substance Use Disorder - Formulary Medication Assisted Treatment (Formulary MAT)
Substance Use Disorder Clinically Managed Withdrawal Management/ Detox - Initial Authorization Only
Substance Use Disorder Medically Monitored Withdrawal Management/ Detox - Initial Authorization Only
Please note - the list above represents the most frequently accessed service types
Outpatient services for service types above always requires prior auth from BH Plan Partner when rendered by a provider with a Prior Authorization Fee for Service (PA FFS) contract.

Services that Require Prior Authorizations

Acute Inpatient	Respite Services – Adult
Applied Behavioral Analysis (ABA)	Subacute Services – Youth
Community Based Intensive Treatment- Youth	Substance Use Disorder Day Treatment – Adult
Crisis Stabilization Services- Youth	Substance Use Disorder Day Treatment – Youth
Dialectical Behavior Therapy	Substance Use Disorder – Non-Formulary Medication Assisted Treatment (Non-Formulary MAT)
Eating Disorder Treatment – Partial Hospitalization and Intensive Outpatient	Substance Use Disorder Residential Treatment
Eating Disorder Treatment – Residential Treatment	Substance Use Disorder/ Dual Diagnosis Residential Treatment- Youth
Electroconvulsive Therapy	Substance Use Disorder/ Dual Diagnosis Residential Treatment- Adult
Enhanced Crisis Stabilization Services - Youth	Substance Use Disorder High Intensity Medically Monitored Residential- Adult
Level D Early Childhood Outpatient MH Services - Youth	Substance Use Disorder Clinically Managed Withdrawal Management/ Detox - Continued Stay Authorizations
Level D Home Based Stabilization Outpatient MH Services - Youth	Substance Use Disorder Medically Monitored Withdrawal Management/ Detox - Continued Stay Authorizations
Level D Transition Age Youth Outpatient MH Services	Transcranial Magnetic Stimulation
Level D Intensive Case Management MH Services - Adult	Subacute Services – Youth
Partial Hospitalization	Substance Use Disorder Day Treatment – Adult
Psychiatric Day Treatment Services – Youth	Substance Use Disorder Day Treatment – Youth
Psychiatric Residential Treatment Services – Youth	
Psychological Testing	
Respite Services – Youth	

Mental Health Practice Guidelines

Acute Inpatient

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Inpatient Utilization Management Guidelines Youth and Adult Mental Health Inpatient protocol for Health Share Members. Refer to the Standardization of Inpatient Mental Health UM Policies and Procedures			
Acute inpatient psychiatric services are intensive, 24 hour services, occurring in an appropriately licensed hospital. Services are provided under the supervision of a licensed psychiatrist and are focused on reducing immediate risk due to dangerousness to self or others, grave disability, or complicating medical conditions (co-occurring with a mental health condition) that leave the individual at significant risk. Treatment is highly intensive and is provided in a secure environment by a multidisciplinary team of qualified mental health professionals. Services may include an initial assessment, history and physical,	**All Admission Criteria Must be Met:** • Client must have or be suspected of having a covered primary mental health disorder covered by the Oregon Health Plan that is the cause of the signs and symptoms that make consideration of hospitalization necessary • The client must be medically stable and medical causes have been ruled out as the source of the mental or behavioral symptoms • Less restrictive levels of care must have been explored, including increasing the intensity of	**At least two of the following are present:** • The persistence of psychiatric problems that resulted in the admission to a degree that continues to meet admission criteria • The emergence of additional problems that meet admission criteria • A severe reaction to medication or the need for further monitoring and adjustment of dosage that required 24 hour medical supervision • Daily progress notes document that the client's mental health problem(s) are responding to or are likely to	**At least one of the following must be met:** • Documented treatment goals and objectives have been substantially met • Individual has achieved symptom or functional improvement back to baseline in resolving issues that resulted in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

individual, group, family and/or activity therapies, social skill development, nutritional care, medically appropriate physical health care, and room and board * Re-assessment is considered complete when adequate time has lapsed from when the individual arrived intoxicated to the ED and verified by a UA, BAL or self-report and the clinical presentation remains the same after the individual is considered sober in the clinical judgment of medical personnel. A 2PndP UA or BAL is not required by the BHPP UR staff. ** Criteria related to individuals presenting with Co-occurring symptoms	outpatient treatment, and demonstrated to be less likely to be effective, more intrusive, unavailable or too dangerous • Admission cannot be strictly for the purpose of temporary housing or due to homelessness • For individuals presenting with intoxication due to alcohol, sobering must occur and the individual must be ***re-assessed**** prior to approval for an inpatient stay. • For other substances, if the individual meets the criteria for "a clear and reasonable inference of danger to self or others", admission will be approved. ** **At least one of the following is present:** • A clear and reasonable inference of danger to self or others. ** • Dangerous assaultive or other uncontrolled behavior, including extensive damage to	respond to the current treatment plan • Evidence of active discharge planning in collaboration with UR Coordinator and/or RAE Care Coordinator • Evidence of active treatment including modification of treatment plan where progress is limited • No less restrictive level of care that would meet the client's and public's need for safety is accessible • The client's need for continued care is not for the primary purpose of temporary housing or due to homelessness Please Note: This is baseline criteria that are being regionally applied by Health Share-Clackamas County, Multnomah and Washington. Each Behavioral Health Plan Partner (BHPP) may decide to approve someone that is above the baseline criteria based on allowable resources (example: co-occurring member admitted by one BHPP because	

	property, not due to substance abuse • Inability to provide for basic needs, safety and welfare • Acute deterioration in mental health functioning causing exacerbation of other medical conditions • The need for regulation of psychotropic medication that cannot be safely done without 24-medical supervision	of additional information about the member or a less restrictive setting such as respite is available but deemed not appropriate for the member).	

Community Based Intensive Treatment (CBIT) / Intercept Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Community-Based Intensive Treatment (CBIT) is a comprehensive, individualized service package that includes a mixture of professional, paraprofessional and natural supports and resources which are intended to maintain or reintegrate children and adolescents in their home and community and reduce out of home placements that are the result of mental health issues. Services will be available in the home, school and community. Services and crisis intervention will be available 24 hours per day.	**Both must be met:** • Covered diagnosis on the prioritized list • Current serious to severe functional impairment in multiple areas **And two of the following:** • Serious risk of harm to self or others due to symptoms of mental illness • Serious impairment of parent/Youth relationship to meet the developmental and safety needs • Significant risk of disruption from current living situation due to symptoms related to a mental health diagnosis. • Transition from a higher level of service intensity (step-down) to maintain treatment gains	**Must meet all of the following:** • Capable of additional symptom or functional improvement at this level of care • Evidence of active discharge planning with the youth/family • Needs cannot be met at lower level of care	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care. • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP with medication management and/or appropriate community supports.

A face-to-face response will be provided when requested and clinically indicated. Services are time-limited with the goal of transition to a lower level of care. Referrals for clients in acute care, sub-acute or residential settings will be prioritized and services will be initiated prior to discharge. CBIT differs from Crisis Stabilization in several ways including no maximum authorization length and that CBIT is not used as a diversion from an inpatient hospital admission. *Authorization Length*: 1 month	• Multiple system involvement requiring substantial coordination • Extended or repeated crisis episode(s) requiring increased services • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service **Must meet 3 of the following:** • Client needs an intake within 72 hours • Hospital and/or subacute admission within the last month. • Client needs rapid access to medication management or requires medication management on a frequent basis. • In order to see improvement, access to in person crisis response or skills training is needed. • Level of aggression requires potentially two on-call staff to respond.		

Enhanced Community Based Intensive Treatment (ECBIT)

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Enhanced Community-Based Intensive Treatment (ECBIT) is a comprehensive, individualized service package that includes a mixture of professional, paraprofessional and natural supports and resources which are intended to maintain or reintegrate children and adolescents in their home and community and reduce out of home placements that are the result of mental health issues. Services will be available in the home, school and community. Services and crisis intervention will be available 24 hours per day. A face-to-face response will be provided when requested and clinically indicated. Services are time-limited with the goal of	**Must meet all of the following:** • Covered diagnosis on the prioritized list • Current serious to severe functional impairment in multiple areas • Severe crisis and safety needs require frequent in-person after hours and weekend support services. • Inability to be placed or maintained in a family or foster care setting due to severe emotional or behavioral needs. • Youth is currently unhoused and living in a DHS supervised setting (does not include youth in a BRS setting). **And two of the following:** • Serious risk of harm to self or others due to symptoms of mental illness	**Must meet all of the following:** • Capable of additional symptom or functional improvement at this level of care • Evidence of active discharge planning with the youth/family • Needs cannot be met at lower level of care • Youth continues to be unhoused, in a DHS supervised setting outside of a family or foster care placement (does not include youth in BRS setting) • Continued need of frequent in-person crisis and safety support services.	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care. • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP with medication management and/or appropriate community supports.

transition to a lower level of care. Referrals for clients in acute care, sub-acute or residential settings will be prioritized and services will be initiated prior to discharge. CBIT differs from Crisis Stabilization in several ways including no maximum authorization length and that CBIT is not used as a diversion from an inpatient hospital admission. *Authorization Length*: 1 month	• Serious impairment of parent/Youth relationship to meet the developmental and safety needs • Current disruption from living situation due to symptoms related to a mental health diagnosis. • Transition from a higher level of service intensity (step-down) to maintain treatment gains • Multiple system involvement requiring substantial coordination • Extended or repeated crisis episode(s) requiring increased services • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service **Must meet 3 of the following:** • Client needs an intake within 72 hours		

	• Hospital and/or subacute admission within the last month. • Client needs rapid access to medication management or requires medication management on a frequent basis. • In order to see improvement, access to in person crisis response or skills training is needed. • Level of aggression requires potentially two on-call staff to respond.		

Crisis Stabilization Services

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Crisis stabilization services are a rapid response, community based alternative to inpatient hospitalization or subacute admission for Youth age 4 through their 18th birthday. The intent of these services is to allow a Youth to remain in the community and to provide stabilization and service planning in a natural setting where Youth and youth remain connected with family and other community supports. The crisis stabilization team will work flexible hours to remain available 24 hours a day, including evenings and weekends, to meet a family's needs and actively work toward transitioning them to a less intensive treatment	**Must meet all of the following criteria:** • Youth is an OHP member enrolled with Health Share of Oregon at the time services are delivered • Youth has an OHP covered "above-the-line", DSM 5, non- substance use, diagnosis which is the focus of the needed mental health treatment. Treatment is not directed primarily to resolve placement issues related to abuse, neglect or caregiver incapacity OR behavior, conduct or substance use problems. Treatment is likely to alleviate symptoms and/or improve functioning • Youth cannot be adequately served by other community resources (i.e.	**Must meet both of the following:** • Capable of additional symptom or functional • improvement at this level of care • Evidence of active discharge planning with the youth/ family	**At least one of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care

option. These supports are intended to be short term (30-90 days in length), and will include assessment, individual and family therapy, psychiatric care, case management, care coordination, skills training and respite. Psychiatric care will be provided monthly, at minimum, and the psychiatrist will be available for at least weekly consultation with the clinical team as needed. Services will be flexible and tailored in frequency, intensity, type and duration to meet the individual Youth and family's needs. Services will be provided creatively, with attention to what is needed to safely maintain the Youth in the community setting, and may include flexible services such as overnight staff in a family home, skills training and support at the school, daily parent coaching, etc.	primary care clinics, substance abuse treatment programs, other community resources), • Youth must have been determined to have met medical necessity criteria for inpatient psychiatric hospitalization or psychiatric subacute treatment, or the Youth is discharging from an inpatient hospitalization without an established mental health provider who can support their needs. • Substance use/Intoxication or developmental disability must be ruled out as the primary cause of the signs and symptoms that lead to the request for treatment • The client must be medically stable and medical causes have been ruled out as the source of the mental or behavioral symptom. • Less restrictive levels of care must have been explored, including increasing the intensity of		

Treatment will be authorized 30 days at a time, with a maximum of a 90 day service time. Within 30 days of initial treatment, the crisis stabilization team will determine whether continued treatment at a level of care preauthorized by the BHPP's (Level D, PRTS, PDTS) is necessary in order to sustain a high level of community based support for the Youth and family. The crisis stabilization team will actively work on transitioning the Youth to an outpatient provider if it is determined that the Youth does not meet criteria for treatment at a level of care preauthorized by the BHPP's. A 30 day authorization will be provided to allow the crisis stabilization team to transition to the next mental health provider.	treatment, and demonstrated to be less likely to be effective, more intrusive, unavailable or too dangerous. **<u>At least one of the following is present:</u>** • A clear and reasonable inference of danger to self or others • Dangerous assaultive or other uncontrolled behavior, including extensive damage to property, not due to substance abuse • Inability to provide for basic needs, safety and welfare • Acute deterioration in mental health functioning causing exacerbation of other medical conditions		

Dialectical Behavior Therapy

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria

Dialectical Behavioral Therapy (DBT) is a service requiring an exceptional needs pre-authorization. DBT is a specialized evidence-based treatment specifically for members whose needs exceed the offerings of other available services through Health Share. Additionally, the member's mental health condition and symptoms should be considered likely to benefit from more intensive services that will increase safety or reduce the need or use of more acute and crisis services.
 	
DBT is a specialized service that is an empirically supported, comprehensive treatment that is effective for treating complex mental health problems (The
	The member must be referred by a mental health professional, preferably a current QMHP from a contracted agency.
	
	AND ALL OF THE FOLLOWING:
	• Member's primary diagnosis is an OHP covered mental health diagnosis;
	  ○ Primary medical condition and/or substance use diagnoses have been ruled out as primary cause of symptoms;
	  ○ DBT has been shown to be an efficacious treatment modality for member's presenting problem and diagnoses;
	• Demonstration of recent (within the last six months) overutilization of acute and crisis services including but not limited to hospitalization, subacute, respite, and provider panel
		The member must meet ALL of the following:
		• Member continues to meet criteria for OHP covered mental health diagnosis and demonstrates ongoing capacity and ability to engage in and benefit from DBT
		• Member is actively engaged in DBT program and treatment components according to treatment provider expectations
		• Member demonstrates progress as measured by member's baseline level of functioning prior to receipt of DBT services. This may include the following:
		  ○ Decrease in self-destructive
			The member must meet ONE of the following:
			• Continued stay criteria is no longer met
			• Continued progress toward treatment goals can be accomplished through less intensive services and member's mental health symptoms can be managed by routine outpatient services.
			• Member shows no use of crisis/acute care services(emergency department visits, inpatient, subacute, respite)
			• Per clinician report and treatment plan tracking process, member is applying skills learned in DBT to life situations the majority of the time (member is not expected to be applying skills 100% of time)

Linehan Institute, 2015). DBT can be applied with a variety of mental health problems and is especially effective for clients who have difficulty managing and regulating their emotions, suicidality, and are high utilizers of crisis services. Initial authorization: 6 months Continued Stay authorization: 6 months	resources due to inability of outpatient network provider to meet the clinical needs of a member. • Recurrent suicidal behaviors, gestures or threats, or self-mutilating behaviors that are unresponsive to multiple treatment attempts and do not represent member's baseline level of functioning. • There is an adequate and well documented trial of outpatient treatment that has been ineffective at addressing member's symptoms and behaviors (i.e., history of appropriate outpatient treatment not being able to decrease use of crisis services, suicidal ideation, and/or suicide attempts). • Member needs to be in treatment with current outpatient provider, preferably Health Share contracted provider, unless there is an extenuating circumstance that prevents this.	behaviors (suicidal ideation, self-harm, suicide attempts) ○ Decrease in acute psychiatric symptoms with increased functioning in activities of daily living ○ Reduction in number of crisis and acute care services (emergency department visits, inpatient, subacute, respite) ○ Objective signs of increased engagement ○ Demonstrated increase in application of skills learned in DBT to life situations per treatment plan progress, clinician report, and use of the safety plan	• Despite efforts to address member's mental health diagnoses and symptoms, member is not presently likely to significantly benefit from further DBT services due to lack of participation or engagement in treatment, chronic substance use, or other treatment interfering behavior(s).

	• Documented history of multiple unsuccessful outpatient treatment episodes. • Member demonstrates capacity to engage in the DBT treatment modality and no interfering factors are present that may limit member's ability to benefit from DBT treatment (i.e., limited cognitive capacity, psychosis, chronic methamphetamine use, medical condition). This will be determined by UR specialist's clinical judgment. • Member is not dependent on and is not actively abusing substances that are likely to interfere with benefitting from DBT services. • There must be a reasonable expectation that DBT will stabilize and/or improve the member's symptoms and behaviors.	• Member continues to make progress toward goals but has not fully demonstrated an ability to self-manage and use learned skills effectively. • Active discharge planning begins at admission and continues throughout treatment. Provider and member are actively working toward discharge and being able to manage mental health symptoms by routine outpatient provider. • Provider should actively be working on transitioning member to less intensive outpatient provider when member seems to be nearing readiness for transition.	

Eating Disorder Treatment: Partial Hospitalization (IOP) Services			
Service Description	**Criteria for Authorization**	**Concurrent review criteria**	**Transition/ Discharge Criteria**
Structured, short term treatment setting. Generally services are provided for a minimum of 6 hours per day, 5 days per week. Partial hospitalization may be used as a "step down" from inpatient services to assist the individual with transition to outpatient services. Partial hospitalization is also used when outpatient treatment has been or is expected to be unsuccessful or the individual's symptoms cannot be managed in an outpatient setting. The individual must have the ability to control eating disorder behaviors and be safely treated at this level of care.	**Medical:** • Medically stable **Suicidality:** • None present • If present, consider if program is equipped to handle or another level of care should be considered **Weight as % of healthy body weight:** • Generally>80% **Presence of Distorted Body Image as defined by:** • A brain disorder that causes preoccupation with an imagined defect in appearance, or if a slight physical anomaly is present, the person's concern is markedly excessive. The preoccupation causes clinically significant distress or impairments in daily functioning. Symptoms	Continued stay is based on progress in treatment or treatment plan is reviewed and amended to eliminate barriers to achieving discharge goals. Progress as indicated by general trending upward of: • BMI if client if anorectic • % of meals completed without supervision if anorectic. Progress as indicated by general trending downward of: • Incidents of restricting without supervision • Incidents of purging without supervision • Incidents of over-exercising when unsupervised	• Continued stay criteria no longer met • Continued progress toward treatment goals can be accomplished at a less intensive level of care • After an adequate trial that includes reformulation of treatment interventions, member does not show measurable progress in treatment • Behavioral, psychological or medical problems necessitate transfer to a more intensive level of care • Discharging the member to a less intensive level of care does not pose a threat to the individual, others, or property

	overlap with primary eating disorders and therefore cannot be diagnosed as a separate condition during the active eating disorder. **Motivation:** • Partial motivation • Cooperative • Preoccupied with intrusive thoughts >3 hours/day **Co-occurring:** • Presence of comorbid condition may influence choice of level of care including other medical conditions, substance use, etc. • Consider impact of mental health condition on eating disorder **Structure needed for eating/weight gain:** • Needs some structure to gain weight **Ability to control compulsive exercising:** • Some degree of external structure beyond self-control **Purging Behaviors:**	The individual is motivated and is actively engaged in the treatment process. Active discharge planning to include natural supports (if available) in terms of developing plan to maintain treatment gains.	

	• Can greatly reduce incidents of purging in an unstructured setting • No significant medical complications such as electrocardiographic or other abnormalities resulting in the need for potential hospitalization **Environmental Stress** Others able to provide at least limited support and structure		

Eating Disorder Treatment: Residential Treatment			
Service Description	**Criteria for Authorization**	**Concurrent review criteria**	**Transition/ Discharge Criteria**
Residential treatment provides intensive, 24 hour services in an appropriately licensed mental health facility. Services are provided by a multidisciplinary team under the supervision of a licensed psychiatrist and are focused on reducing immediate risk due to dangerousness to self, grave disability, or complicating medical conditions.	**Medical:** • Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed **Suicidality:** • None present. • If present, consider if program is equipped to handle or another level of care should be considered	Continued stay is based on progress in treatment or treatment plan is reviewed and amended to eliminate barriers to achieving discharge goals. Progress as indicated by general trending upward of: • BMI if client if anorectic • % of meals completed without staff direction.	• Continued stay criteria no longer met • Continued progress toward treatment goals can be accomplished at a less intensive level of care • After an adequate trial that includes reformulation of treatment interventions, member does not show measurable progress in treatment • Behavioral, psychological or medical problems

	Weight as % of healthy body weight: • Generally <85% **Presence of Distorted Body Image as defined by:** • A brain disorder that causes preoccupation with an imagined defect in appearance, or if a slight physical anomaly is present, the person's concern is markedly excessive. The preoccupation causes clinically significant distress or impairments in daily functioning. Symptoms overlap with primary eating disorders and therefore cannot be diagnosed as a separate condition during the active eating disorder. **Motivation:** • Poor to Fair motivation • Cooperative with highly structured treatment • Preoccupied with intrusive thoughts 4-6 hours/day **Co-occurring:** • Presence of comorbid condition may influence	Progress as indicated by general trending downward of: • Incidents of restricting without staff direction • Incidents of purging without staff direction • Incidents of over-exercising without staff direction. The individual is motivated and is actively engaged in the treatment process. Active discharge planning to include natural supports (if available) in terms of developing plan to maintain treatment gains.	necessitate transfer to a more intensive level of care • Discharging the member to a less intensive level of care does not pose a threat to the individual, others, or property

	choice of level of care including other medical conditions, substance use, etc. • Consider impact of mental health condition on eating disorder **Structure needed for eating/weight gain:** • Needs supervision at all meals or will restrict eating **Ability to control compulsive exercising:** • Some degree of external structure beyond self-control **Purging Behaviors:** • Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging **Environmental Stress** • Severe family conflict or problems or absence of family so member is unable to receive structured treatment in home OR Member lives alone without adequate support system		

Eating Disorder Treatment: Inpatient Hospitalization Services			
Service Description	**Criteria for Authorization**	**Concurrent review criteria**	**Transition/ Discharge Criteria**
Structured eating disorder treatment program occurring in a medical hospital with focus on eating disorder and not just for medical stabilization. Services are provided by a multidisciplinary treatment team under the supervision of a licensed psychiatrist and are focused reducing immediate risk due to dangerousness to self, grave disability, or complicating medical conditions.	**Medical: Adults** • Heart rate <40 bpm • Blood Pressure <90/60 mmHg • Glucose <60mg/dl • Potassium <3 mEq/L • Electrolyte imbalance • Temperature <97.0F • Dehydration • Hepatic, renal, or cardiovascular organ compromise requiring acute treatment OR • Poorly controlled diabetes **Medical: Youth** • Heart rate near 40 bpm • Orthostatic Blood Pressure changes (> 20 bpm increase in heart rate or >10 mmHG to 20 mmHg drop) • Blood pressure <80/50 mmHG • Hypokalemia, hypophosphatemia, or hypomagnesemia **Suicidality:** • Specific plan with high lethality or intent; admission may also	Continued stay will be based on review of the interdisciplinary medical record which provides evidence of the individual's: • failure to meet targeted weight after adequate caloric intake; and • inability to control binging and purging that require supervision of meal consumption and locked bathroom; and • lack of insight into symptoms, illness, and cannot ambulate safely; or • start on a trial of a new medication and requires monitoring for adverse side effects or reactions.	• Continued stay criteria no longer met • Continued progress toward treatment goals can be accomplished at a less intensive level of care • After an adequate trial that includes reformulation of treatment interventions, member does not show measurable progress in treatment • Behavioral, psychological or medical problems necessitate transfer to a more intensive level of care • Discharging the member to a less intensive level of care does not pose a threat to the individual, others, or property

	be indicated in members with suicidal ideas or after attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk **Weight as % of healthy body weight:** • Generally <85% OR • Acute weight decline with food refusal even if not <85% of healthy body weight **Presence of Distorted Body Image as defined by:** • A brain disorder that causes preoccupation with an imagined defect in appearance, or if a slight physical anomaly is present, the person's concern is markedly excessive. The preoccupation causes clinically significant distress or impairments in daily functioning. Symptoms overlap with primary eating disorders and therefore cannot be diagnosed as a separate condition during the active eating disorder.		

	Motivation: • Very Poor to poor motivation • Uncooperative or cooperative only in highly structured treatment • Preoccupied with intrusive, repetitive thoughts **Co-occurring:** • Presence of comorbid condition may influence choice of level of care including other medical conditions, substance use, etc. • Consider impact of mental health condition on eating disorder **Structure needed for eating/weight gain:** • Needs supervision during and after all meals OR • nasogastric/special feeding modality **Ability to control compulsive exercising:** • Some degree of external structure beyond self-control **Purging Behaviors:** • Needs supervision during and after all meals and in bathrooms		

	• Unable to control multiple daily episodes of purging that are severe, persistent, and disabling despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities **Environmental Stress** • Severe family conflict or problems or absence of family so member is unable to receive structured treatment in home OR • Member lives alone without adequate support system		

Electroconvulsive Therapy

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Electroconvulsive Therapy (ECT) is an exceptional needs treatment intervention considered only after various trials of different therapies and medications, of various classes, have been exhausted. ECT must be conducted in a fully equipped medical facility with the capability to manage any complications. An anesthesiologist assists in the procedure that can be provided either on an inpatient or outpatient basis. ECT is generally used as a secondary treatment when the individual has not responded to medication and/or psychotherapy. ECT can be used if previous ECT treatment brought about favorable results for the patient.	The decision to administer ECT must be based on an evaluation of the risks and benefits involving a combination of factors that include psychiatric diagnosis, type and severity of symptoms, prior treatment history and response, and identification of possible alternative treatment options. A request for an ECT assessment must be made in writing by the prescriber (either a licensed psychiatrist or psych nurse practitioner) to the assigned Behavioral Health Plan Partner (BHPP). Client must voluntarily agree to ECT assessment. BHPP Medical Directors will determine whether or not criteria are met for an assessment to be covered by an ECT provider.	ECT is generally authorized for 6 to 12 sessions. Additional sessions may be authorized in the following circumstances: • Persistence of symptoms with improvement but where maximum benefit has not been achieved **OR** • New symptoms or problems that meet clinical criteria for ECT have emerged.	Discharge may occur when: • Continued progress toward treatment goals can be accomplished at a less intensive level of care. **OR** • After an adequate treatment trial has been completed that includes a reformulation of treatment interventions, **OR** • Individual does not show measurable progress in treatment. **OR** • Authorized sessions have been completed.

ECT can also be used if the patient is pregnant and has severe mania or depression and the risks of providing no treatment outweigh the risks of providing ECT. ECT is not to be used in the presence of cognitive or neurological deficits	To be considered for an ECT assessment, the individual must meet the following criteria: • A Diagnosis of either Major Depression, Bipolar Affective Disorder or Catatonia associated with another medical or mental disorder. **AND** • History of severe suicidal ideation and/or vegetative state, **AND/OR** • High level of acuity at time of request must be demonstrated not only chronicity of symptoms.		

Outpatient Mental Health Services – Level A-D

Youth and Family

Assessment Plus Two
The assessment plus two authorization covers up to three sessions with no time limit. The purpose of this assessment phase is threefold: (1) gather adequate clinical information to recommend the appropriate Level of Care (LOC); (2) assess the client's ability and willingness to engage in treatment; and (3) determine the client's functional capacity. Please note that initial engagement and assessment/screening services (e.g. 90899, T1023, 90791, 90792, H0002, H0031) do not require a covered diagnosis on the 32Tprioritized list32T. However, if other clinical services such as individual or family therapy are employed as part of the Assessment Plus Two process, they do require a covered diagnosis on the prioritized list, as well as an assessment and service plan in compliance with applicable OARs and the fee schedule.
Level A-D Determination of Level of Care
There may be specific situations when the clinician determines that a particular LOC is appropriate, based on their assessment of the client's clinical presentation and needs; however, the client is either unable or unwilling to engage in treatment at that level. That inability to engage can be secondary to either a lack of interest in treatment and/or functional limitations in their ability to engage. In those situations, the clinician may request authorization at a lower LOC, to reflect the client's interest/readiness for change and/or functional ability to participate. If a clinician decides to request authorization at a lower LOC than is clinically indicated (per the paragraph above), the LOC Registration form requires that the clinician explain how he/she will work with the client towards the goal of receiving all clinically indicated services.

Mental Health Outpatient: Level A Youth and Family			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Generally office based, these outpatient mental health services are designed to quickly promote, or restore, previous level of high function/stability, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued as an individual is able to function more effectively. Outpatient services include evaluation and assessment; individual and family therapy; group therapy; medication management; and case management. *Examples Include:* • *An individual has already taken effective action and is*	• Covered diagnosis on the prioritized list AND • The need for maintenance of a medication regimen (at least quarterly)that cannot be safely transitioned to a PCP, OR • A mild or episodic parent-Youth or family system interactional problem that is triggered by a recent transition or outside event and is potentially resolvable in a short period of time OR • Transitioning from a higher level of service (step down) in order to maintain treatment gains and has been stable at his level of functioning for 3-4 visits AND • Low acuity of presenting symptoms and minimal functional impairment AND • Home, school, community impact is minimal	**Continues to meet admission criteria AND is capable of additional symptom or functional improvement at this level of care.**	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

in the maintenance phase of treatment to maintain baseline • *Client who is pre-contemplative regarding engagement in a higher level of care* • *Primarily psychiatric services for on-going medication management* • *Treatment will be limited and target a specific behavior, interaction, or symptom* • *Natural supports are available consistently. Important life activities prohibit frequent participation in services.* • *Client who is receiving services from other systems such as DD, APD, DHS, etc.* **Authorization Length**: **One year**			

Mental Health Outpatient: Level B Youth and Family			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Generally office based, these outpatient mental health services are designed to promote, restore, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued as an individual is able to function more effectively. Outpatient services may include some combination of evaluation and assessment; individual and family therapy; group therapy; medication management; *and as needed case management, skills training, and peer/family support.* *Examples include:* • *An individual who is taking effective action in treatment or who is prepared and determined to take effective action in treatment.*	• Covered diagnosis on the prioritized list **AND** • Mild to Moderate functional impairment in at least one area (for example, sleep, eating, self-care, relationships, school behavior or achievement) **OR** • Mild to Moderate impairment of parent/Youth relationship to meet the developmental and safety needs **OR** • Transition from a higher level of service intensity (step-down) to maintain treatment gains	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional • improvement at this level of care • Significant cultural and language barriers • impacting ability to fully integrate symptom • management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

• *Client who is pre-contemplative regarding engagement in a higher level of care* • *Low frequency sessions, but client/family requires consistency and regular practice over time in order to develop new skills. ,habits and routines to compensate for lagging skills* • *Parent-child interactional problem may be causing some on-going impairment, therefore parent training may be a primary focus of treatment* • *Client may have more barrier to natural/informal supports and requires case management* • *Family utilizes services well and benefits from treatment, but struggles to internalize or generalize skill development* • *Home based services may be appropriate when there are cultural or developmental considerations* **Authorization Length**: **Six months**			

Mental Health Outpatient: Level C Youth and Family			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
These services can be provided in any of the following: clinic, home, school and community. These services are designed to prevent the need for a higher level of care, or to sustain the gains made in a higher level of care, and which cannot be accomplished in either routine outpatient care or other community support services. Outpatient services may include some combination of evaluation and assessment; individual and family therapy; medication management, case management, skills training, peer/family support, respite and some phone crisis support *Examples include:*	**Criteria for Early Childhood and School-Age and Adolescents:** • Covered diagnosis on the prioritized list **At least one of the following:** • Significant risk of harm to self or others • Moderate to severe impairment of parent/Youth relationship to meet the developmental and safety needs • Moderate to severe functional or developmental impairment in at least one area, **AND For School-Age and Adolescents at least one of the following:** • Risk of out of home placement or has had multiple transition in placement in the last 6	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom • Management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

• *Client who is pre-contemplative regarding engagement in a higher level of care* • *Client needs higher frequency of sessions and a combination of multiple service types* • *In vivo coaching and mild to moderate phone crisis support required to interrupt dysfunctional patters of interaction and integrate new skills* • *Unstable placement due to caregiver stress* • *Complex symptoms for which targeted caregiver /parent education is required to improve child function* **Authorization Length: Six months**	months due to symptoms of mental illness • Risk of school or daycare placement loss due to mental illness or development needs. • Multiple system involvement requiring coordination and case management • Moderate to severe behavioral issues that cause chronic family disruption • Extended crisis episode requiring increased services; • Recent acute or subacute admission (within the last 6 months) • Significant current substance abuse for which integrated treatment is necessary • Transition from a higher level of service intensity (step-down) to maintain treatment gains • Youth and/or family's level of English language skill and/or acculturation is not sufficient to achieve symptom or functional improvement without case management		

Mental Health Outpatient: Level D Early Childhood: Ages 0-5			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Early Childhood Home based stabilization services are provided, at an intensive level, in the home, school and community with the goal of stabilizing behaviors and symptoms of the child that led to referral. May include some combination of evaluation and assessment; individual and family therapy (including evidenced based early childhood models); medication management; case management; skills training; peer/family support; respite at an increased frequency; school/day care support and consultation; group parenting education/training. Treatment is not directed primarily to resolve placement OR behavior.	**All must be met:** - Covered diagnosis on the prioritized list - Current serious to severe functional impairment in multiple areas - Treatment intensity at a lower level of care insufficient to maintain functioning **And four of the following:** -Serious risk of harm to self or others due to symptoms of mental illness (e.g. impulsivity resulting in elopement, aggression, sexualized behaviors, expressed intent to harm self or others, extreme irritability resulting in unsafe responses from others, etc.…) - Serious impairment of caregiver capacity to meet the developmental and safety needs of their child (e.g. parent in substance abuse	**Must meet all of the following:** - Capable of additional symptom or functional improvement at this level of care - Parent or caregiver is actively involved with treatment -Evidence of active discharge planning with the youth/family - Needs cannot be met at lower level of care	**At least ONE of the following must be met:** - Documented treatment goals and objectives have been substantially met, -No longer meets criteria for this level of care or meets criteria for a higher level of care, -Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, -It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to Lower level of care with medication management and/or appropriate community supports.

Services and interventions should be focused on both young child and caregiver. Crisis intervention is available 24/7 both by phone and in person. May be appropriate as an alternative to Psychiatric Day Treatment, Psychiatric Residential Treatment, or Inpatient Treatment. Typically children referred to this level of care are demonstrating attachment and/or trauma related symptoms resulting in possible loss of early childhood placement. **Authorization Length: Initial 90 days, one month thereafter** For the initial 90 day authorization request, the provider will submit the following: Mental Health Assessment updated within the last 60 days OR progress notes for the last 30 days **AND** Updated Treatment Plan	treatment, domestic violence, mental illness, etc.) - Significant risk of disruption from current living situation due to child's symptoms related to a mental health diagnosis. - Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service -Multiple recent placement changes for child resulting in increase in emotional / behavioral dysregulation -Current significant risk of losing day care or early childhood education placement due to behaviors related to mental health symptoms or trauma (e.g. sexualized behavior, increased arousal, persistent negative emotional state, biting, extreme tantrums, aggression towards others, etc.)		

For all subsequent 30 day authorization requests, the provider will either have a verbal conversation with ENCC to justify continued stay **OR** submit the last 30 days of progress notes. In the event of a potential denial via the verbal authorization, backup clinical would be requested prior to the NOA. The Health Plan will be responsible for the completion of the Level of Care Treatment Registration Form			

Level D (Home Based Stabilization) Youth and Family - Ages 6 -17			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Home based stabilization services are provided, at an intensive level, in the home, school and community with the goal of stabilizing behaviors and symptoms that led to referral. May include some combination of evaluation and assessment; individual and family therapy; medications management; case management; skills training; peer/family support, and respite at an increased frequency. Treatment is not directed primarily to resolve placement OR behavior, conduct or substance abuse problems Crisis intervention is available 24/7 both by phone and in person. *Examples:*	**Both must be met:** • Covered diagnosis on the prioritized list • Current serious to severe functional impairment in multiple areas **And one of the following:** • Treatment intensity at a lower level of care insufficient to maintain functioning • Hospital or subacute admission in the last 30 days **And two of the following:** • Serious risk of harm to self or others due to symptoms of mental illness • Serious impairment of parent/Youth relationship to meet the developmental and safety needs • Significant risk of disruption from current living	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP with medication management and/or appropriate community supports.

• *Client who is pre-contemplative regarding engagement in a higher level of care* • *Client is discharging from residential stay or has had multiple acute/sub-acute placements in the last 6 months.* Children and Youth are no longer required to meet criteria for Wraparound Care Coordination to be considered for this level of care. **Authorization Length: Initial 90 days, one month thereafter** For the initial 90 day authorization request, the provider will submit the following: • Mental Health Assessment updated within the last 60 days OR progress notes for the last 30 days **AND** • Updated Treatment Plan	situation due to symptoms related to a mental health diagnosis. • Transition from a higher level of service intensity (step-down) to maintain treatment gains • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service		

For all subsequent 30 day authorization requests, the provider will either have a verbal conversation with ENCC to justify continued stay **OR** submit the last 30 days of progress notes. In the event of a potential denial via the verbal authorization, backup clinical would be requested prior to the NOA. The Health Plan will be responsible for the completion of the Level of Care Treatment Registration Form			

Outpatient Mental Health Services – Level A-D

Adult

Assessment Plus Two
The assessment plus two authorization covers up to three sessions with no time limit. The purpose of this assessment phase is threefold: (1) gather adequate clinical information to recommend the appropriate Level of Care (LOC); (2) assess the client's ability and willingness to engage in treatment; and (3) determine the client's functional capacity. Please note that initial engagement and assessment/screening services (e.g. 90899, T1023, 90791, 90792, H0002, H0031) do not require a covered diagnosis on the prioritized list. However, if other clinical services such as individual or family therapy are employed as part of the Assessment Plus Two process, they do require a covered diagnosis on the prioritized list, as well as an assessment and service plan in compliance with applicable OARs and the fee schedule.
Level A-D Determination of Level of Care
There may be specific situations when the clinician determines that a particular LOC is appropriate, based on their assessment of the client's clinical presentation and needs; however, the client is either unable or unwilling to engage in treatment at that level. That inability to engage can be secondary to either a lack of interest in treatment and/or functional limitations in their ability to engage. In those situations, the clinician may request authorization at a lower LOC, to reflect the client's interest/readiness for change and/or functional ability to participate. If a clinician decides to request authorization at a lower LOC than is clinically indicated (per the paragraph above), the LOC Registration form requires that the clinician explain how he/she will work with the client towards the goal of receiving all clinically indicated services.

Mental Health Outpatient: Level A: MRDD/IDD or Medication Only Adult			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Specialized assessment and medication management by a MD or PMHNP and minimal adjunct case management *Examples include:* • *Individual with a developmental disability that will not benefit from talk therapy.* • *Client who is pre-contemplative regarding engagement in a higher level of care* • *Individuals that have progressed to the point in care where they only require complex medication management (e.g. injectable medications)* • *For adults only medication, this can be clients in a general outpatient setting or who fit the criteria for Severe and Persistently Mentally Ill (SPMI)* **Authorization Length:1 year**	• Covered diagnosis on the prioritized list **AND one of the following:** • Need for care coordination with DD services and ongoing medication management • Need for medication management for a medication regime that is more complicated than generally provided in primary care.	**Continues to meet admission criteria AND is capable of additional symptom or functional improvement at this level of care.**	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

Mental Health Outpatient: Level A
Adult
(Note: There is no "Level A SPMI")

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Services are designed to promote, restore, or maintain social/emotional functioning and are focused and time limited with services discontinued when client's functioning improves. Outpatient services include evaluation and assessment; individual and family therapy; group therapy; medication management. Outpatient services are office based. *Examples include:* • *Mild depression or anxiety that cannot be addressed only by primary care intervention.*	Both of the following: • Covered diagnosis on the prioritized list • Episodic depression, anxiety or other mental health conditions with no recent hospitalizations and limited crisis episodes within the past year **AND at least one of the following:** • Mild functional impairment • A presentation that is elevated from baseline	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

• *Client who is pre-contemplative regarding engagement in a higher level of care* **Authorization Length:1 year**			

Mental Health Outpatient: Level B Adult			
SERVICE DESCRIPTION	**CRITERIA FOR AUTHORIZATION**	**CONCURRENT REVIEW CRITERIA**	**TRANSITION/ DISCHARGE CRITERIA**
Services are designed to promote, restore, or maintain social/emotional functioning and are focused and time limited with services discontinued when client's functioning improves. Services may include evaluation and assessment; individual and family therapy; group therapy; medication management. Case management is not generally required by individual. Outpatient services are more commonly provided in the	• Covered diagnosis on the prioritized list **AND at least one of the following:** • Moderate risk of harm to self or others • Moderate functional impairment in at least one area such as such as housing, financial, social, occupational, health, and activities of daily living • Individual has a marginalized identity which creates barriers to	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in

office and with more frequency than Level A. *Examples include:* • *Moderate risk of harm to self or others requiring more frequent sessions* • *Client who is pre-contemplative regarding engagement in a higher level of care* • *Individual is stepping down from higher level of care and demonstrating symptom or functional improvement* • *Individual's clinical presentation is affecting at least one functional domain such as work or relationships and therefore would benefit from more frequent services* **Authorization Length:1 year**	receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports		admission to this level of care Meets criteria for a different level of care due to change in symptoms or function at this level of care

Mental Health Outpatient: Level B SPMI Adult			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Services are designed to promote recovery and rehabilitation for adults with SPMI. These services instruct, assist, and support an individual to build or improve skills that have been impaired by these symptoms. Comprehensive assessment and treatment planning focus on outcomes and goals with specific interventions described to achieve them. **Emphasis is placed on linkages with other services and coordination of care**. Services are primarily office based and may include evaluation and assessment;	**ALL** of the following: • Covered diagnosis on the prioritized list • No hospitalizations or major crisis episodes within the past year • No risk of harm to self or others or risk of harm to self or others that is consistent with baseline presentation. **AND at least two of the following:** • Symptoms related to the mental illness result in a moderate functional impairment and are fairly well controlled	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or

consultation; case management; individual and family therapy; group therapy; medication management; skills training; supported employment; family education and support; relapse prevention; occasional crisis support. Diagnoses generally covered under this authorization type: Schizophrenia; Schizoaffective Disorder; and Psychosis. Diagnoses can also include Mood and Anxiety Disorders that are severe and persistent in nature and have serious impact on activities of daily living. *Examples include:* • *Individuals functioning at baseline would benefit from additional life skill development and social support in order to maintain independence*	• Individual able to navigate system with minimal to moderate support OR has supports (such as family or AFH) in place to meet client's needs • Low to moderate psychosocial stress (housing and benefits are generally stable) • Individual is generally functioning at baseline • Individual has extended periods of abstinence when a co-occurring disorder exists and risk factors are minimal • Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports		function at this level of care

• *Client who is pre-contemplative regarding engagement in a higher level of care* • *Individual is stepping down from higher level of care and demonstrating symptom or functional improvement Foster home example or natural supports example--- supported structure living* **Authorization Length: One Year**			

Mental Health Outpatient: Level C Adult			
SERVICE DESCRIPTION	**CRITERIA FOR AUTHORIZATION**	**CONCURRENT REVIEW CRITERIA**	**TRANSITION/ DISCHARGE CRITERIA**
Services are designed to promote, restore, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued when client's functioning	• Covered diagnosis on the prioritized list **AND at least two of the following must be met:** • Risk of harm to self or others or risk of harm to self or others that is escalated from baseline	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with

improves. This includes individuals who meet the criteria for Transitional Age Youth. Services may include more community-based services and can include evaluation and assessment; individual and family therapy; group therapy; medication management; consultation; case management; skills training; crisis support; relapse prevention, hospital diversion; integrated substance abuse treatment *Examples Include:* • *Mental health issues are compounded by risk of loss of housing due to extended periods of crisis* • *Individual may benefit from care coordination and case management*	• Moderate functional impairment in at least two areas (such as housing, financial, social, occupational, health, activities of daily living.) • At least one hospitalization within the last 6 months • Multiple system involvement requiring coordination and case management • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness • Significant current substance abuse for which integrated treatment is necessary • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses • Extended or repeated crisis episode(s) requiring increased services • Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation	• Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

• *Client who is pre-contemplative regarding engagement in a higher level of care* **Authorization Length:1 year**	barriers is not sufficient to achieve symptom or functional improvement without additional supports • Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination		

Mental Health Outpatient: Level C SPMI Adult			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Services are designed to promote recovery and rehabilitation for adults with severe and persistent symptoms of mental illness. These services instruct, assist, and support an individual to build or improve skills that have been impaired by these symptoms. Comprehensive assessment and treatment planning focus on outcomes and goals with specific interventions described to achieve them. **Emphasis is placed on linkages with other services and coordination of care**. Services may include: evaluation and assessment, outreach, consultation, case management, counseling,	Two of the following: • Covered diagnosis on the prioritized list • Significant assistance required to meet basic needs such as housing and food • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses **AND at least two of the following:** • At least one hospitalization within the past year • Symptoms related to the mental illness result in a moderate to significant functional impairment	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

medication evaluation and management, daily structure and support, skills training, family education and support, integrated substance abuse treatment, supported employment, relapse prevention, hospital diversion, crisis intervention and supported housing. Diagnoses generally covered under this authorization type: Schizophrenia; Schizoaffective Disorder; Psychosis, Mood and Anxiety Disorders that are severe and persistent in nature and have serious impact on activities of daily living *Examples Include:* • *Individual requires increased coordination in order to meet basic needs such as safety, housing and food.* • *Individual's symptoms are partially controlled.*	and are only partially controlled • Risk of harm to self or others or risk of harm to self or others that is escalated from baseline • Multiple system involvement requiring substantial coordination • Extended or repeated crisis episode(s) requiring increased services • Significant current substance abuse for which treatment is necessary • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness • Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve		

• *Client who is pre-contemplative regarding engagement in a higher level of care* • *Additional care coordination linking client to resources will prevent hospitalization.* • *Intensive Case Management (ICM) client or Assertive Community Treatment (ACT) client who is not ready to engage in additional services* **Authorization Length: 1 year**	symptom or functional improvement without additional supports • Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination		

Mental Health Outpatient: Level D: Adult Intensive Case Management (ICM) or Transition Age Youth (TAY)			
Service Description	**Criteria for Authorization**	**Concurrent Review Criteria**	**Transition/ Discharge Criteria**
Services are provided at an intensive level in the home and community with the goal of stabilizing behaviors and symptoms that led to admission. Programs include an array of coordinated and integrated multidisciplinary services designed to address presenting symptoms in a developmentally appropriate context. These services could include group, individual, family, psycho educational services, crisis management and adjunctive services such as medical monitoring. Services include multiple or extended treatment visits.	***Criteria for ICM:*** • Covered diagnosis on the prioritized list **AND at least two of the following:** • 2 or more inpatient admissions in the past year • Recent discharge from the State Hospital (within the past year) • Civil Commitment or Discharge from the state hospital within the past year) • Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided • Severe deficits in skills needed for community	Criteria for ICM and TAY: **Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service • Eviction or homelessness is likely if level of care is reduced	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

Diagnoses generally covered under this authorization type: Schizophrenia; Schizoaffective Disorder; Psychosis, Mood and Anxiety Disorders are severe and persistent in nature and have serious impact on activities of daily living. 24/7 telephonic crisis support is provided by the ICM or TAY team Services differ from Assertive Community Treatment (ACT) in frequency and in 24/7 face-to-face crisis availability *Examples Include:* • *ICM: Adult with severe life skill deficits, secondary to mental health symptoms, with a recent transition from State or Inpatient Hospitalization requires coordination of multidisciplinary services in the home.*	living as well as a high degree of impairment due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses **OR at least three of the following:** • Intractable, severe major symptoms • Significant cultural or linguistic barriers exist • Significant criminal justice involvement • Requires residential placement if intensive services are not available • Not engaged in services but deemed at high risk of harm related to their mental illness		

• *TAY: Teen or young adult with persistent psychotic symptoms requires intensive, in home, care coordination in order to meet treatment, housing, and employment needs.* **Authorization length: 1 year**	• Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness • Co-occurring addiction diagnosis • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness ***Criteria for TAY:*** • Covered diagnosis on the prioritized list **AND at least one of the following:** • 2 or more inpatient admissions in the past year • Recent discharge from the Youth's Secure Inpatient Adolescent Program or long term Psychiatric Residential Treatment Services • Residing in an inpatient bed or supervised community residence and		

	clinically assessed to be able to live in a more independent living situation if intensive services are provided • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness, **OR at least three of the following:** • Intractable, severe major symptoms • Significant cultural or linguistic barriers exist • Significant criminal justice involvement • Requires residential placement if intensive services are not available • Not engaged in services but deemed at high risk of harm related to their mental illness • Severe deficits in skills needed for community living as well as a high degree of impairment due		

	to symptoms of mental illness • Co-occurring addiction diagnosis • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses		

Mental Health Intensive Outpatient Treatment (I/OP)

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Intensive Outpatient provides stabilization of acute and severe mental illness in a structured, short term treatment setting with the intention of returning or connecting the member to their treating community provider. Services are provided for an aggregate between 10 and 19 hours a week. Treatment is provided by a multidisciplinary treatment team, including psychiatric and nursing care as part of an active treatment program. Treatment also includes coordination and discharge planning with the community provider who will be treating the client after discharge from Intensive Outpatient. Intensive Outpatient is intended to be alternative to hospitalization. Individuals	**All the following must be met:** • Mental health diagnosis covered by the Oregon Health Plan Prioritized List of Health Services • Mental health condition that requires a structured program with frequent nursing and medical supervision, intervention • Is not responsive to treatment provided in a less intensive outpatient setting • Would be at risk to self or others , and/or would experience a significant deterioration of functioning if not in an intensive outpatient program • There is reasonable expectation that the level of care will stabilize and/or improve the member's symptoms and behaviors or prevent further regression, and the member must be able to participate and	**At least one of the following:** • Clinical evidence that an attempt at therapeutic re-entry to a less intensive level of care would result in exacerbation of the psychiatric illness to the degree that continued Intensive Outpatient is needed • Clinical criteria for facility based Intensive Outpatient treatment services are met due to continuation of presenting DSM behaviors and/or symptoms, or the emergence of new symptoms, or the emergence of new and/or previously unidentified DSM behaviors and/or symptoms • Persistence of problems that caused the admission to an extent that continues to meet the admission criteria	**At least one of the following:** • Concurrent review criteria is no longer met • The individual is not making progress toward treatment goals and there is no expectation of progress at this level of care despite treatment planning changes • Stepping up to inpatient level of care, **or** stepping down to a lesser intensive level of outpatient care is indicated • The documented treatment plan, goals , and objectives have been substantially met; • There is a discharge plan with follow-up appointments in place prior to discharge.

may be referred from the community to stabilize a crisis, from the emergency room as a diversion from inpatient, or from inpatient to transition back into the community with supports. Partial hospitalization services are generally authorized for 5 – 10 days at a time. Provider to follow local BHPP pre-authorization process.	benefit from the level of care requested. • Acute stage symptoms have been stabilized, but could require a minimum of 3 hours of care for a minimum of 3 times a week to further support stabilization.	• The member requires frequent nursing and medical supervision • Emergence of additional problems that meet the admission criteria • Active discharge planning begins at admission, and continues throughout treatment • Member is currently involved and cooperating with the treatment process • Member is not actively participating in treatment and meets one of the following: o Treatment plan and/or discharge goals are reformulated to address the lack of expected progress o There are measurable indicators that the member is progressing toward active engagement in treatment.	

Mental Health Partial Hospitalization

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Partial Hospitalization provides stabilization of acute and severe mental illness in a structured, short term treatment setting with the intention of returning or connecting the member to their treating community provider. Services are provided for an aggregate of services greater than 20 hours per week. Treatment is provided by a multidisciplinary treatment team, including psychiatric and nursing care as part of an active treatment program. Treatment also includes coordination and discharge planning with the community provider who will be treating the client after discharge from Partial Hospital. Partial hospitalization is intended to be alternative to hospitalization. Individuals	**All the following must be met:** • Mental health diagnosis covered by the Oregon Health Plan Prioritized List of Health Services • Mental health condition that requires a structured program with frequent nursing and medical supervision, intervention • Is not responsive to treatment provided in a less intensive outpatient setting • Would be at risk to self or others if not in a partial hospital program • Presence of or regression towards acute stage symptoms that do not meet the criteria for 24 hour inpatient treatment, but could require an aggregate of services greater than 20 hours per week • Substance use or intoxication has been ruled out as a primary cause of	**At least one of the following:** • Clinical evidence that an attempt at therapeutic re-entry to a less intensive level of care would result in exacerbation of the psychiatric illness to the degree that continued partial hospitalization is needed • Persistence of problems that caused the admission to an extent that continues to meet the admission criteria • Emergence of additional problems that meet the admission criteria • Member is currently involved and cooperating with the treatment process • Member is not actively participating in treatment and meets one of the following: ○ Treatment plan and/or discharge goals are reformulated to address	**At least one of the following:** • Concurrent review criteria is no longer met • The individual is not making progress toward treatment goals and there is no expectation of progress at this level of care despite treatment planning changes • Stepping up to inpatient level of care, **or** stepping down to a lesser intensive level of outpatient care is indicated • The documented treatment plan, goals , and objectives have been substantially met; • There is a discharge plan with follow-up appointments in place prior to discharge.

may be referred to partial hospitalization from the community to stabilize a crisis, from the emergency room as a diversion from inpatient, or from inpatient to transition back into the community with supports. Partial hospitalization services are generally authorized for 7 – 10 days at a time. Provider to follow local BHPP pre-authorization process.	presenting mental or behavioral symptoms	the lack of expected progress o There are measurable indicators that the member is progressing toward active engagement in treatment.	

Psychiatric Day Treatment Services

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Psychiatric Day Treatment Services (PDTS) is a comprehensive, inter-disciplinary, non-residential, community-based program consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program Services include 24 hour, seven days a week treatment responsibility for admitted Youth and on-call capability at all times to respond directly or by referral to the treatment needs of admitted Youth. Admission not solely for the purpose of placement or at the convenience of the family, the provider or other Youth serving agencies. Initial Authorization: 90 days Continued Stay: 30 days	**Criteria for Early Childhood (ages 0-6) and School-Age and Adolescents: All must be met:** • Mental health diagnosis covered by the Oregon Health Plan Prioritized List of Health Services and be paired with PDTS that would be the focus of treatment • Mental health symptoms requiring active mental health treatment in order to improve functioning • Resources available in the school and community have been tried and are not meeting the youth's treatment needs **Additional Criteria for Early Childhood. One of the following:** • Identified mental health symptoms acuity and intensity impacting the Youth or youth's ability to	**Must meet both of the following:** • Capable of additional symptom or functional improvement at this level of care • Active engagement of the home school district in identification of education placement at discharge **And three of the following:** • Acuity, severity and frequency of psychiatric symptoms at admission have not decreased or stabilized; • Emergence of new psychiatric symptoms requiring day treatment level of care; • Attempts at re-entry into a less restrictive day care, preschool or school setting have resulted in exacerbated or re-	**At least one of the following:** • Concurrent review criteria no longer met or youth meets criteria for a higher level of care • Youth has met treatment goals and is able to function successfully in school or appropriate educational placement • Youth has practiced and integrated new skills sufficiently to utilize them in lower level of care • A school placement has been identified by the home district prior to transition • Youth's mental health needs can be met a lower level of service • Youth requires 24-hour, seven day a week active mental health treatment under the direction of a psychiatrist (Psychiatric

	function in a day care or preschool setting • Complex developmental presentation impacting one or more of the following areas: o Social o Emotional o Neurobiological o Physical and/or o Sensory Development **School-Age and Adolescents. Both of the following:** • Identified mental health symptoms acuity and intensity impact the Youth or youth's ability to function in a school setting • A milieu environment along with psychiatric support are documented as needed and are not available through intensive community-based services or is a diversion or stepdown from psychiatric residential treatment	emergence of symptoms of the mental health illness that can't be mitigated with school and community supports • Individualized plan of care with specific interventions, and Youth/adolescent's response to the interventions and progress toward treatment goals or reflects that treatment goals can't be achieved in a less restrictive setting • A transition plan has been developed and has a timeline for implementation including active Child and Family Team meetings or interdisciplinary review meetings and engagement with school, community resources, and natural supports • Ongoing active engagement of home school district in identification of educational placement at discharge	Residential Treatment Services) • Family withdraws the Youth from services or chooses not to engage in services • Youth and/or family is not fully able to engage in services or has achieved maximum benefit **Additional Consideration:** • For high school students, timing of transition to minimize the negative impact of academic progress related to achieving credits should be taken into consideration

Psychiatric Residential Treatment Services

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Behavioral health care program certified under OAR 309-032-1540 to provide 24-hour, 7 day a week active mental health treatment under the direction of a psychiatrist. *Primary diagnoses not "paired" with PRTS on the Oregon Health Plan Prioritized List of Health Services and generally not considered for authorization:* • *Attention Deficit Hyperactivity Disorder* • *Adjustment Disorder* • *Substance Use Disorder* • *Intellectual Developmental Disorder*	To be considered for admission, the individual must meet the following criteria: • serious emotional disturbance or mental health condition that requires active psychiatric treatment 24 hours/7 days a week; • resources available in the community do not meet the Youth's treatment needs • behaviors responsive to PRTS include active psychosis and risk of harm to self or others • mental health condition at a level of acuity or severity that it is impacting all areas of life and functioning • requires intensive psychiatric oversight and active mental health treatment in order to improve functioning	Concurrent review conducted every 14 days. To meet criteria for continued stay, the Youth must be capable of additional symptom or functional improvement at this level of care and the interdisciplinary record must document: • The PRTS provider has measurable indicators of whether the client's mental health symptoms that led to the admission, or as identified post-admission, are responding to the treatment plan. This may be reflected in a change in CASII or ECSII score (within a domain or overall) • Documentation is obtained from the PRTS provider of ongoing discharge planning related to the discharge criteria in the Plan of Care. • The client's record documents any attempts at	Discharge occurs when: • Youth/adolescent has met treatment goals and is able to function successfully in the home, school and community; **and** • Youth's mental health needs can be met a lower level of service; **or** • the family withdraws the Youth from services; **or** • the family chooses not to engage in services; **or** • Youth has achieved maximum benefit; **or** • the Child and Family Team (if involved in Wraparound) or treatment team determines that the Youth and/or family is not fully able to engage in services and recommends discharge.

	Contraindications for PRTS:
	
	• Diagnoses not found responsive to/ best practice to treat in PRTS:
	  ○ Reactive Attachment Disorder
	  ○ Oppositional Defiant Disorder
	  ○ Conduct Disorder
	
	• Behaviors, independent of a covered mental health diagnosis, not found to be responsive to PRTS:
	  ○ Bullying
	  ○ Physical aggression
	  ○ Sexual offending
	  ○ Property destruction
	  ○ Fire setting
	  ○ Truancy
	  ○ Running away
	  ○ Pattern of defiant behavior
	
	To be considered for admission to PRTS, the Youth/adolescent must meet **all** of the following criteria:
	
	• have a mental health diagnosis covered by the
		re-entry into the community (e.g. overnight or day passes) that have resulted in exacerbation or re-emergence of symptoms of the mental illness and cannot be mitigated with community supports.
		• The treatment plan documents that treatment goals cannot be achieved in a less restrictive setting.
		• Continued stay is not due to the convenience of family or other entities and is not solely for placement
		• The Child and Family Team and/or treatment team determines that the Youth requires a secure inpatient program such as Secure Youth's Inpatient Program (SCIP) or Secure Adolescent Inpatient Program (SAIP) and the client has been accepted and is on the wait list.	

	Oregon Health Plan Prioritized List of Health Services and paired with PRTS that would be the focus of treatment; **and** • admission not solely for purposes of placement or at the convenience of the family, the provider or other Youth serving agencies; **and** • Level of Service Intensity Determination outcome of Level 5 or higher; **and** • written recommendation from the treating psychiatrist indicating: 1) the need and/or reason for a residential level of care; 2) why a less acute level of care would not be sufficient to address the psychiatric need; 3) the benefit to the Youth and family from this recommended treatment episode; **and** • Approved Certificate of Need (CONS) completed prior to admission which certifies the need for this level of care		

Psychological Testing

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Psychological testing is defined as "a measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process" (American Psychological Association, 2000). Psychological testing requires the application of appropriate normative data for interpretation or classification and may be used to guide differential diagnosis in the treatment of psychiatric disorders. Psychological Testing includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., WAIS, Rorschach, MMPI. Psychological Testing must consist of face-to-face	Must meet **all** of the following: • Primary purpose of testing is to obtain diagnostic clarification of a covered mental health diagnosis; specifically, to address a particular diagnostic and/or treatment question(s) which cannot be answered through usual means of clinical interview and collateral data review (including review of any previous psychological testing). • Test results are expected to significantly impact the patient's treatment, thereby leading to improvement in the patient's mental health condition and/or functioning. • Patient has had a full mental health assessment completed by an approved behavioral healthcare	Concurrent review is required if the psychologist will exceed the number of hours pre-authorized. This will only be reviewed in exceptional needs cases where circumstances justify need for additional hours of testing and the following must be met: • The psychologist must provide an explanation of why additional hours and testing are needed and why continued authorization is requested. (ie. the member is not tolerating testing so the testing needs to be done in shorter periods of time over a longer time span). • Pre-authorization of additional hours of testing is required.	A written integrated psychological assessment report must be submitted and include the following: • Clinical interview • Summary of collateral information, history and background information; referral question • Summary of all records reviewed, including any previous psychological testing results • Summary of any exceptional issues that arose during the testing process (i.e., why additional time was needed for testing) • Tests administered; results of each test administered • Clinical formulation • Diagnosis and diagnostic justification including rule out of diagnoses as they pertain to referral question

psychological assessment of member and include the following: clinical interview with member and collateral sources; integration of collateral information, including previous psychological or neuropsychological testing, as well as history and background information; tests administered must directly address referral question; and must primarily include tests beyond self-report measures and most often should include psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology. It is also recommended that the member be seen by a Licensed Medical Professional who also recommends testing and the reason(s) why. **Provider requirements:** The provider is a licensed doctoral level psychologist or psychiatrist who is adequately trained in the administration	provider within the six months prior to the request. • Request for testing must be made by a behavioral healthcare provider. • Medical conditions have been ruled out as a primary cause of the mental health condition and/or are not the primary focus of testing (or, in cases where a medical condition is a primary contributing factor, the physical health plan will be engaged in discussion concerning payment for psychological or neuropsychological testing) **Exclusion Criteria (one or more):** • Testing is for educational (IEP/ Learning Disorders), vocational, or legal purposes (including court-ordered testing) • Testing is to assist in determining eligibility for any kind of services (i.e., vocational rehab, disability, IEP, etc.)		• Specific answer(s) to referral question(s) • Clear and individualized clinical recommendations by the authorized psychologist It is recommended that a debriefing of results and assessment is provided to client, guardian, and appropriate treatment providers.

and interpretation of psychological instruments. **Authorization:** Prior authorization must be obtained prior to the start of services and must not exceed the allowable amount based on identified hours to complete testing	• Testing is conducted as a screening tool or part of an initial evaluation. • Testing is requested by patient for personal interest. • Medical condition(s) have been determined to be a primary cause of the mental health condition and/or are not the primary focus of testing (in which case the physical health plan would be responsible for providing requested psychological and/or neuropsychological testing)		

Respite Services

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Respite services are provided to Youth and their families for temporary relief from care giving in order to maintain a stable and safe living environment. Respite services are often utilized to avoid the need for an out of home placement or a higher of level of care. Crisis or planned respite services is provided in either a licensed 24 hour facility or foster home certified and licensed by a contracted mental health provider. Services and supports during the respite stay include supervision, structure, stabilization and support. Respite is not authorized solely for the convenience of the family or the service providers. Crisis Respite is authorized for up to 7 days	To be considered for admission, the individual must meet the following criteria: • engaged with an identified treatment provider that is requesting authorization of respite as an intervention; and • does not meet the criteria for 24-hour acute care but needs temporary, structured, supportive, non-medical, safe environment due to an exacerbation or increase of difficult, unsafe, destructive behaviors due to family stress or conflict or caregiver stress; and • natural and informal supports (such as extended family, friends, neighbors, church members, etc) have been explored and are not available or adequate; and • symptoms and/or behaviors are not due to substance abuse/intoxication, a medical condition, or other circumstance	Crisis respite is initially authorized for 1-7 days to assist with stabilization. On-going authorization for crisis respite is provided for an additional 1-7 days as indicated by a lack of stabilization either of the Youth/adolescent, caregiver or home environment. Planned respite, when part of an on-going treatment plan or Plan of Care is authorized for a total of 14 days in a 6 month period. Adjustments to the authorization are requested through the Child and Family Team.	Discharge occurs when: • the Youth/adolescent and family have benefited from respite services and the youth is no longer at risk of losing their current community setting; or • the Youth/adolescent is in need of a higher level of care. • Exceeding the standard authorization for this intervention and there is not documentation supporting ongoing medical necessity. Respite can be an ongoing and/or episodic service based on the clinical needs of the Youth/adolescent and family.

Contact the local BHPP for Planned Respite initial and continued stay authorization	not covered by the mental health benefit.		

Respite Services

Adult

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Respite services are short-term environmental and symptom stabilization related to mental health symptoms. Respite services are provided in a 24-hour licensed facility .Services must be reasonably expected to improve or maintain the condition and functional level of the individual and prevent relapse or hospitalization. Services include assessment, supervision, structure and support, and limited care coordination secondary to external mental health case management, medication administration, and room and board.	To be considered for admission, the individual must meet the following criteria: • is unable to care for basic needs at current living situation due to the impact of the psychiatric illness on behavior and functioning; and • does not meet the criteria for 24-hour acute care but needs a temporary, structured, supportive environment while mental health needs are actively addressed; and • symptoms and/or behaviors are not due to substance abuse/intoxication, a medical condition, or other circumstance not covered by the mental health benefit; and. • does not have an unstable medical condition requiring medical supervision; and • is not experiencing acute withdrawal symptoms.	Continued stay criteria includes: • persistence of problems that caused the admission to a degree that continues to meet the admission criteria; or • the emergence of additional problems that meet the admission criteria; or • discharge planning and/or attempts at re-entry into the community have resulted in or would result in an exacerbation of the mental health symptoms to the degree it would result in the need for hospitalization	Discharge criteria include: • evidence that the mental health symptoms have stabilized, diminished or resolved; and • there is no longer evidence of a risk of hospitalization; and • the improved mental health status allows the individual to provide for their own safety and basic needs; and • resources and a support system exist in the community that are adequate to provide the level of support and supervision needed for safety, self-care and effective treatment.

Homelessness is not an exclusion criteria as long as the primary reason for respite is due to a psychiatric or mental health condition. Respite should not be used solely for the purpose of housing or placement. Projected length of stay is generally 3-7 days Contact local BHPP for initial and continued stay authorization length of stay	Additionally, the individual may meet one or more of the following criteria: • requires stabilization due to a recent medication adjustment or a supportive environment during a medication change • is unstable in current living situation due to medication non-compliance and is willing to take medications as prescribed while in respite • feels unsafe towards self due to current psychiatric condition and/or current stressors and is willing to contract for safety while in respite • requires stabilization following a hospital discharge while community-based services are being arranged Individuals may be excluded from authorization based on recent history of physical assault, homicidal behavior, arson, sexual offenses, weapon possession, anti-social personality or other factors that would make the individual a high-risk in this environment.		

Subacute Services

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Subacute services, for Youth ages 5-17 require 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment with 16-hour skills nursing, structured treatment milieu and 3:1 Youth to staff ratio. Initial Authorization: Until next business day Continued Stay authorization: 2 business days.	**All the following must be met:** • Been evaluated by a qualified mental health professional, other licensed clinician, or medical professional and demonstrates symptomatology consistent with current DSM 5 diagnosis, requiring and can reasonably be expected to respond to therapeutic intervention • Consent has been obtained by Youth's legal guardian. If no legal guardian is available, DHS has been contacted, has emergency custody and has provided consent for admission • Youth/ adolescent cannot be safely maintained and effectively treated at a less intensive level of care	**The following must be met:** • Treatment team concurs that continued stabilization is needed and there is an active transition plan from this level of care, **AND** **At least one of the following:** • acuity, severity and frequency of psychiatric symptoms at admission have not decreased or stabilized • emergence of new psychiatric symptoms requiring continued evaluation and treatment • a severe reaction to medication or the need for further monitoring and adjustment of dosage that requires 24 hour medical supervision	**At least one of the following:** • Documented treatment goals and objectives have been substantially met • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care • OP treatment services have been initiated that will allow for the current treatment needs to safely be supported in the community.

	• Youth/ adolescent has a place to live and/or the community team is actively addressing placement needs which will be resolved within the two weeks of the subacute stay **At least two of the following must be met:** • Is acutely ill due to a primary psychiatric illness and requires psychiatric care for evaluation and treatment • Co-occurring presentation of substance use and psychiatric symptoms and has been medically cleared or completed Detox protocol and the psychiatric symptoms are the reason for the admission • Deemed to be at high risk of harm to self or others as evidenced by the following: ○ Presents with thoughts of suicide with a possible plan or ○ Has recently attempted suicide or engaged in significant self-harm		

	○ Thoughts *and* possible plans of homicide or harming others ○ Been assaultive towards others and is judged to be at continued risk of violence to others ○ Has severe impulsivity resulting in harm to self or others including significant risk-taking behaviors • Need for a mental health assessment or evaluation that cannot be safely provided in a less restrictive setting **Contraindications to Subacute:** • Requires 1:1 staffing • Requires daily face-to-face psychiatric evaluation and management • Requires chemical or mechanical restraint • Primary presentation related to criminal behavior • Substance use disorder without co-occurring psychiatric diagnosis		

	• Medically unstable or requiring medical management including eating disorders that are not stable or require oversight by a registered dietician or unstable or labile diabetes • Major medical or surgical illness that prevents active participation in a treatment program such as: Ongoing IV Therapy; Cardiac telemetry monitoring; Continuous oxygen or support equipment or ongoing suctioning		

Substance Use Disorder Practice Guidelines

Substance Use Disorder Outpatient - ASAM Levels 1.0, 2.1, and 2.5

Youth

SERVICE DESCRIPTION
Outpatient services can be delivered in a variety of settings and generally provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services. Therapies offered in outpatient involve skilled treatment services, which may include individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, addiction pharmacotherapy, or other therapies. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. For patients with mental health conditions, the issues of psychotropic medication, mental health treatment, and their relationship to substance use and addictive disorders are addressed as the need arises. While the services provided the outpatient levels of care are generally the same, the number of hours per week varies. Such services are provided in an amount, frequency, and intensity appropriate to the patient's multidimensional severity and level of function. Levels of care can be fluid where patients move between levels of care based on their needs. The ASAM Criteria outlines the following services hours for youth in outpatient: Level 1.0 Outpatient: Fewer than 6 hours per week Level 2.1 Intensive Outpatient: 6-19 hours per week Level 2.5 Partial Hospitalization/ Day Treatment: 20 or more hours per week Outpatient Addictions and Mental Health services may be offered in any appropriate setting that meets state licensure or certification criteria, including OARs 309-019-0100 through 309-019-0220.

Criteria for Authorization
To be appropriate for outpatient services, the individual must meet diagnostic criteria in the DSM-5 for a Substance Use Disorder of at least Mild or Moderate severity and meet ASAM criteria for the level of care provided. For co-occurring capable and co-occurring enhanced programs, the patient also meets DSM-5 criteria for a covered mental health disorder.

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Level 1.0 Outpatient	No withdrawal risk	None or very stable, or is receiving concurrent monitoring	Meets all of the following: A.) the adolescent is not at risk of harm, B.) there is minimal interference, C.) Minimal to mild impairment, D.) the adolescent is experiencing minimal current difficulties with activities of daily living, but there is significant risk of deterioration, E.) the adolescent is at minimal imminent risk, which predicts a need for some monitoring or interventions	Willing to engage in treatment, and is at least contemplating change, but needs motivating and monitoring strategies	Able to maintain abstinence or control use and pursue recovery goals with minimal support	Family and environment can support recovery with limited assistance

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Level 2.1 Intensive Outpatient	Experiencing minimal withdrawal, or is at risk of withdrawal	None or very stable, or distracting from treatment at a less intensive level of care. Such problems are manageable at Level 2.1	Meets one or more of the following: A.) The adolescent is at low risk of harm, and he or she is safe between sessions, B.) Mild interference requires the intensity of this level of care to support treatment engagement, C.) Mild to moderate impairment, but can sustain responsibilities, D.) The adolescent is experiencing mild to moderate difficulties with activities of daily living, and requires frequent monitoring or interventions, E.) The adolescent's history (combined with the present situation) predicts the need for frequent monitoring or interventions	Requires close monitoring and support several times a week to promote progress through the stages of change because of variable treatment engagement, or no interest in getting assistance	Significant risk of relapse or continued use, or continued problems and deterioration in level of functioning. Has poor prevention skills and needs close monitoring and support	Adolescent's environment is impeding his or her recovery, and adolescent requires close monitoring and support to overcome that barrier

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Level 2.5 Partial Hospitalization / Day Treatment	Experiencing mild withdrawal, or is at risk of withdrawal	None or stable, or distracting from treatment at a less intensive level of care. Such problems are manageable at Level 2.5	One or more of the following: A.) The adolescent is at low risk of harm, and he or she is safe overnight, B.) Moderate interference requires the intensity of this level of care to support treatment engagement, C.) Moderate impairment, but can sustain responsibilities, D.) The adolescent is experiencing moderate difficulties with activities of daily living and requires near-daily monitoring or interventions, E.) The adolescent's history (combined with the present situation) predicts the need to near-daily monitoring or interventions	Requires a near-daily structured program to promote progress through the stages of change because of little treatment engagement or escalating use and impairment, or no awareness of the role that substances pay in his or her present problems	High risk of relapse or continued use, or continued problems and deterioration in level of functioning. Has minimal prevention skills and needs near-daily monitoring and support	Adolescent's environment renders recovery unlikely without near-daily monitoring and support, or frequent relief from his or her home environment

Concurrent Review Criteria

It is appropriate to retain the patient at the present level of care if one or more of the following criteria are met:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

or

- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

and/or

- New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. This level is the least intensive at which the patient's new problems can be addressed effectively

Transition/ Discharge Criteria

It is appropriate to transfer or discharge the patient from the present level of care if he or she meets one of the following criteria:

- The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;

or

- The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated;

or

- The patient has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated;

or

- The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care

Substance Use Disorder Outpatient - ASAM Levels 1.0 (opioid treatment program and outpatient), 2.1, and 2.5

Adult

Service Description
Outpatient services can be delivered in a variety of settings and generally provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services. Therapies offered involve skilled treatment services, which may include individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, addiction pharmacotherapy, or other therapies. Acupuncture related to treatment of a substance use disorder may also be provided by qualified professionals. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. For patients with mental health conditions, the issues of psychotropic medication, mental health treatment, and their relationship to substance use and addictive disorders are addressed as the need arises. “Opioid Treatment Services” is an umbrella term that encompasses a variety of pharmacological and non-pharmacological treatment modalities. The term is intended to broaden understandings of opioid treatments to include all medications used to treat opioid use disorders and the psychosocial services that are offered concurrently with these pharmacotherapies. Pharmacological agents include opioid agonist medications such as methadone and buprenorphine, and opioid antagonist medications such as naltrexone. Such services are provided in an amount, frequency, and intensity appropriate to the patient’s multidimensional severity and level of function. Levels of care can be fluid where patients move between levels of care based on their needs. The ASAM Criteria outlines the following services hours for adults in outpatient: Level 1.0 Outpatient: Fewer than 9 hours per week Level 2.1 Intensive Outpatient: 9-19 hours per week Level 2.5 Partial Hospitalization/ Day Treatment: 20 or more hours per week Outpatient Addictions and Mental Health services may be offered in any appropriate setting that meets state licensure or certification criteria, including OARs 309-019-0100 through 309-019-0220. Opioid Treatment Programs must meet Federal and State regulations, including 42 CFR 8.12 and OARs 410-020-0000 through 410-020-0085.

Typically Opioid Treatment Services are provided in an outpatient specialty addictions setting. Patients receiving Level 2 (Intensive Outpatient or Day Treatment) or Level 3 (Residential) substance use and co-occurring treatment can be referred to, or be concurrently enrolled in, an Opioid Treatment Program. Opioid Treatment Services can be provided with appropriate collaborations across different settings and at many levels of care, depending on the patient centered assessment findings in Dimensions 1-6, and the patient's recovery-oriented goals.

Criteria for Authorization

To be appropriate for outpatient services, the individual must meet diagnostic criteria in the DSM-5 for a Substance Use Disorder of at least Mild or Moderate severity and meet ASAM criteria for the level of care provided. For co-occurring capable and co-occurring enhanced programs, the patient also meets DSM-5 criteria for a covered mental health disorder.

Considerations for Partial Hospitalization/ Day Treatment: *Direct admission* to Level 2.5 is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist)*and* Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist), as well as in at least *one* of Dimensions 4, 5 or 6. *Transfer* to a Level 2.5 program is advisable for the patient who has met the essential treatment objectives at a more intensive level of care and requires the intensity of services provided at level 2.5 in at least one of Dimensions 4, 5 or 6. A patient also may be transferred to Level 2.5 from a Level 1 or Level 2.1 program when the services provided at Level 1 have proved insufficient to address the patient's needs or when those services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admissions criteria

Considerations for Opioid Treatment Services (OTP): To be appropriate for OTP, the individual must meet diagnostic criteria in the DSM-5 for an Opioid Use Disorder of mild, moderate, or severe severity and meet ASAM criteria for Opioid Treatment Program Level 1.0. Patients receiving Level 2 (Intensive Outpatient or Day Treatment) or Level 3 (Residential) substance use and co-occurring treatment can be referred to, or be concurrently enrolled in, an Opioid Treatment Program. Opioid Treatment Services can be provided with appropriate collaborations across different settings and at many levels of care, depending on the patient centered assessment findings in Dimensions 1-6, and the patient's recovery-oriented goals.

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Opioid Treatment Program (OTP) Level 1.0	Physiologically dependent on opioids and requires OTP to prevent withdrawal	None or manageable with outpatient medical monitoring	None or manageable in an outpatient structured environment	Ready to change the negative effects of opioid use, but is not ready for total abstinence from illicit prescription or non-prescription drug use	At high risk of relapse or continued use without OTP and structured therapy to promote treatment progress	Recovery environment is supportive and/or the patient has skills to cope

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Level 1.0 Outpatient	Not experiencing significant withdrawal, or at minimal risk of severe withdrawal. Manageable at Level 1- WM (see Withdrawal Management Criteria)	None or very stable, or is receiving concurrent medical monitoring	None or very stable, or is receiving concurrent mental health monitoring	Ready for recovery but needs motivating and monitoring strategies to strengthen readiness. Or needs ongoing monitoring and disease management. Or high severity in this dimension but not in other dimensions. Needs Level 1 motivational enhancement strategies	Able to maintain abstinence or control use and/or addictive behaviors and pursue recovery or motivational goals with minimal support	Recovery environment is supportive and/or the patient has skills cope

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Level 2.1 Intensive Outpatient	Minimal risk of severe withdrawal, manageable at Level 2-WM (see withdrawal management criteria)	None or not a distraction from treatment. Such problems are manageable at Level 2.1	Mild severity, with potential to distract from recovery; needs monitoring	Has variable engagement in treatment, ambivalence, or a lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change	Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times per week	Recovery environment is not supportive, but with structure and support, the patient can cope

ASAM Level of Care	Dimension 1: Acute Intoxication and/or Withdrawal	Dimension 2: Biomedical Conditions and Complications	Dimension 3: Emotional/ Behavioral or Cognitive Conditions and Complications	Dimension 4: Readiness to Change	Dimension 5: Relapse, Continued Use or Continued Problem Potential	Dimension 6: Recovery Environment
Level 2.5 Partial Hospitalization/ Day Treatment	Moderate risk of severe withdrawal manageable at Level 2-WM (see withdrawal management criteria)	None or not sufficient to distract from treatment, Such problems are manageable at Level 2.5	Mild to moderate severity, with potential to distract from recovery; needs stabilization	Has poor engagement in treatment, significant ambivalence, or a lack of awareness of the substance use or mental health problem, requiring a nearly-daily structured program or intensive engagement services to promote progress through the stages of change	Intensification of addiction or mental health symptoms, despite active participation in a Level 1 or 2.1 program, indicates a high likelihood of relapse or continued use or continued problems without near-daily monitoring and support	Recovery environment is not supportive, but with structure and support and relief from the home environment, the patient can cope

Concurrent Review Criteria

It is appropriate to retain the patient at the present level of care if one or more of the following criteria are met:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

or

- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

and/or

- New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. This level is the least intensive at which the patient's new problems can be addressed effectively

Transition/ Discharge Criteria

It is appropriate to transfer or discharge the patient from the present level of care if he or she meets one of the following criteria:

- The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;

or

- The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated;

or

- The patient has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated;

or

- The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care

Medication Assisted Treatment

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Medication Assisted Treatment (MAT) encompasses a variety of pharmacological Interventions used in the treatment of Opioid Use Disorders or Alcohol Use Disorders. MAT can be provided in a variety of settings, including Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT). These regional guidelines apply to Health Share of Oregon members receiving services in specialty behavioral health settings. In the specialty behavioral health system, Medication Assisted Treatment is provided concurrently with non-pharmacological treatment modalities in all levels of care.	Generic Name: Buprenorphine/ Naloxone Sublingual Film Brand Name: Suboxone Film Tab, Zubsolv Initial Criteria: 1. Does the member have a DSM-5 diagnosis of Opioid Use Disorder? If yes, continue to #2. If no, do not approve. 2. For Opioid Use Disorders, has the member failed an adequate trial of Buprenorphine or Buprenorphine/ Naloxone Tablets including attempts at a mitigating strategy (crushing tablets, taking with food, taking small amounts at a time) AND there has been consideration of Naltrexone tablets and/or Methadone? If yes, continue to #4. If no, go to #3.	Generic Name: Buprenorphine/ Naloxone Sublingual Film Brand Name: Suboxone Film Tab, Zubsolv 1. Has the member maintained abstinence from all substances with the use of Buprenorphine/ Naloxone SL Film based on negative blood or urine toxicology screens, OR maintained ongoing participation in a comprehensive substance use disorder program that includes psychosocial support? If yes, approve for 6 months. If no, continue to #2 2. Is there evidence of significantly reduced utilization of acute care services (ED visits, inpatient, and/or detox services) and/or improved clinical outcomes? If yes approve for 6 months. If no, do not approve.	It is appropriate to transfer or discharge the patient from MAT with Buprenorphine/ Naloxone Sublingual Film if he or she meets one of the following criteria: • The patient has achieved the goals articulated in his or her individualized treatment plan and MAT with one of these medication is no longer needed • The patient is able to transition to a medication, such as methadone or buprenorphine, that does to require prior authorization • The patient has transitioned to MAT with their primary care provider and that provider will work with the patient's physical health plan for prior authorization, if needed

Pharmacological agents include opioid agonist medications such as methadone and buprenorphine, and opioid antagonist medications such as naltrexone. These medications should be used for recovery from substance use disorders, not for the treatment of pain. Please note that prior authorization within the specialty behavioral health system is not required for methadone, buprenorphine, buprenorphine/ naloxone, or. Naltrexone Extended Release Injection (Vivitrol). Prior authorization **is** required for Buprenorphine/ Naloxone Sublingual Film.	3. Has the provider established a case for clear cost-avoidance with Buprenorphine/ Naloxone SL Film for the member from their Opioid Use Disorder AND a trial of or Buprenorphine/ Naltrexone Tablets or Buprenorphine has been determined not appropriate? If yes, continue to #4. If no, do not approve. OR Has the provider established a rationale for why alternate medications are medically contraindicated and provided information on medications tried, adverse outcomes for each, and the dose and duration for each medication? If yes, continue to #4. If no, do not approve. 4. Is there documentation that the member is engaged in a substance use disorder		• The patient no longer meets concurrent review criteria

	treatment program with psychosocial support? If yes, continue to #5. If no, do not approve. 5. Is there documentation that the member is not concurrently prescribed or taking Buprenorphine/ Naloxone, Buprenorphine, or other opiates from another provider? If yes, approve for 6 months. If no, do not approve.		

Substance Use Disorder Residential
ASAM Levels 3.1, 3.3, and 3.5

SERVICE DESCRIPTION	CRITERIA FOR AUTHORIZATION	CONCURRENT REVIEW CRITERIA	TRANSITION/ DISCHARGE CRITERIA

"Residential Alcohol and Other Drug Treatment Program" or Residential Substance Use Disorder Treatment means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with alcohol and other drug dependence, consistent with Level 3 of the ASAM Criteria 3PrdP Edition.
 	
Residential treatment is a 24 hour a day/7 day a week facility-based level of care which provides individuals with substance use disorders therapeutic intervention and specialized programming in a
	To be appropriate for residential treatment, the individual must meet the following conditions
	• Meet DSM-5 criteria for a Substance Use Disorder
	  ○ Moderate or Severe Severity diagnosis
	  ○ Mild severity only if pregnant woman or high risk of medical/behavioral complications
	• Meet ASAM Level III criteria and it is the least restrictive appropriate level of care.
	• Withdrawal Symptoms, if present, are not life threatening and can be safely monitored at this level of care.
	• No medical complications that would preclude
		For continued stay, the individual must continue to meet all the basic elements of medical necessity as defined above.
		
		An individualized discharge plan must have been developed/updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion must be in place but discharge criteria have not yet been met.
		
		<u>At least one of the following must be met-</u>
		A. The treatment provided is leading to measurable clinical improvements in
			Any of the following criteria are sufficient for discharge from this level of care:
			1. The individual's documented treatment plan goals and objectives have been substantially met.
			2. The individual is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care, nor is treatment at this level of care required to maintain the current level of functioning.
			3. Support systems, which allow the individual to be maintained in a less restrictive treatment environment, have been

controlled environment with a high degree of supervision and structure with the purpose of stabilization. Individuals meeting these criteria have multiple coexisting complications of their substance use disorder. This may include mental health, medical, legal or other issues that preclude successful treatment outside of a 24 hour a day therapeutic setting. Services and activities are to be provided in a culturally appropriate manner. Residential treatment addresses stabilization of the identified problems through a wide range of diagnostic and treatment services by reliance on the treatment community setting. Services may address (but are not limited to) the following issues: Addiction/relapse Craving management	participation in this level of care • Cognitively able to participate in and benefit from treatment. <u>At least one of the following must be met-</u> A. The individual suffers from co-occurring psychiatric symptoms that interfere with his/her ability to successfully participate in a less restrictive level of care, but are sufficiently controlled to allow participation in residential treatment. 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	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. B. There is evidence of ongoing reassessment and modification to the ISSP, if the Individual Services and Support Plan (ISSP) implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care. C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment. 2.All of the following must be met: D. The individual and family are involved to the best of their ability in the treatment and discharge	thoroughly explored and/or secured. 4. The individual can be safely treated at an alternative level of care. 5. An individualized discharge plan is documented with appropriate, realistic, and timely follow-up care in place. 6. The individual poses a safety risk to other participants, dependents, or staff (for example, physical/verbal violence, smoking in building, or the use or presence of alcohol or drugs on premises). 7. The individual's mental health or medical symptoms increase to the point that continued treatment is not beneficial at this level of care. The individual has been referred to the appropriate level.

Motivation Trauma Employment Education Life skills Recovery support Housing Criminality Parenting Case Management/Mentoring Culture/Spirituality Mental Health-screening/evaluation Medication monitoring and asst with self admin Family and/or significant other involvement unless otherwise indicated **Residential Treatment for parents with children may also include:** Childcare Child services (e.g. mental health) Parenting skills Parent/Child interaction	in their own substance abuse, or the living situation is severely dysfunctional (including homelessness). C. The individual's social, family, and occupational functioning is severely impaired secondary to substance use disorders such that most of their daily activities revolve around obtaining, using and recuperating from substance abuse. D. The individual is at risk of exacerbating a serious medical or psychiatric condition with continued use and can't be safely treated at a lower level of care. E. Either: • The individual is likely to experience a deterioration of his/her condition to the	planning process, unless there is a documented clinical contraindication. E. Continued stay is not primarily for the purpose of providing a safe and structured environment (unless discharge presents a safety risk to a minor child.) F. Continued stay is not primarily due to a lack of external support unless discharge presents a safety risk to a minor child. **For authorization of continued stay,** the following documentation will be required: • Re-auth form • Copy of current ISSP • Individual progress notes from the previous 10 days of service	

Residential Services for youth may also include: Education Recreation Family and/or significant involvement including DHS, Juvenile Justice and natural supports. Residential treatment must include an Initial Assessment and Individual Service and Support Plan within 24 hours of admission. Residential treatment is not based on preset number of days, and length of stay will vary based on the individual's needs. The use of evidence based practices is expected, to the extent that they are appropriate for the individual.	point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time. • The individual demonstrates repeated inability to control his/her impulses to use elicit substances and is in imminent danger of relapse with resultant risk of harm to self (medically/behaviorally), or others. This is of such severity that it requires 24-hour monitoring/ support/intervention. For individuals with a history of repeated relapses involving multiple treatment episodes, there must be evidence of the rehabilitative potential for the proposed admission, with clear interventions to address non-adherence/poor response to past treatment episodes		

	and reduction of future of relapse risk. **Initial Authorization Review Process** Initial authorization will be for: • Adult & Youth - 30 days • Parent with child*- 60 day * If parent-child reunification is expected within 60 days, the authorization will be considered a "parent with child" authorization The program must notify the appropriate BHPP of intake within 2 business days. Notification must be accompanied by the following clinical information: • Initial assessment, including diagnosis • Justification of level of care, including ○ Presenting problem(s)		

	○ History of previous treatment (successful or not) ○ Drug of choice, longest period of abstinence, most recent use ○ Referral source and contact information ○ Pregnancy status (if appropriate) ○ If parent-child reunification is expected within 60 days, the authorization will be considered a "parent with child" authorization ***Any*** *of the following criteria is sufficient for exclusion from this level of care.* If the individual or dependent child: • Exhibits severe suicidal, homicidal, acute mood disorder, and/or acute thought disorder symptoms, which requires a more intensive level of care. • Can be safely maintained and effectively treated at a less intensive level of care. • Has mental health or medical		

	conditions/impairments that would prevent beneficial utilization of services, or is not medically or psychiatrically stable. • Poses a documented/shown safety risk to the facility, other individuals, themselves or staff.		

Dual Diagnosis Residential Treatment - ASAM Level 3.5

Youth

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria

Support System Requirements:
Programs offer psychiatric services, medication evaluation and laboratory services. Such services are available by telephone within 8 hours and on-site or closely coordinated off-site within 24 hours, as appropriate to the severity and urgency of the patient's mental condition.
 	
Staffing Requirements:
Programs are staffed by appropriately credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques.
 	
Some (if not all) of the addiction treatment
	Must meet the following:
	• Covered mental health diagnosis on the prioritized list AND
	• Recent psychiatric acute or subacute placement within the last 6 months OR
	• Extended or repeated crisis episode(s) requiring increased services AND
	• DSM-5 criteria
	  ○ Moderate or Severe Severity diagnosis
	  ○ Mild severity only if pregnant or high risk of medical/behavioral complication
	
	AND at least two of the following must be met:
	• Significant risk of harm to self or others
	• Moderate to severe impairment of parent/child relationship to meet the developmental and safety needs
		Continues to meet admission criteria AND at least one of the following:
		
		• Capable of additional symptom or functional improvement at this level of care
		• Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service
		• Active Care Coordination is occurring with mental health, A&D and primary care outpatient providers
			At least ONE of the following must be met:
			
			• Documented treatment goals and objectives have been substantially met
			• Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports
			• Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care
			• Meets criteria for a different level of care due to change in symptoms or function at this level of care or maximum therapeutic benefit has been met

professionals should have sufficient cross-training to understand the signs and symptoms of co-occurring mental disorders, and to understand and be able to explain to the patient the purposes of psychotropic medications and their interactions with substance use. The intensity of nursing care and observation is sufficient to meet the patient's needs. **Therapy Requirements:** Programs offer planned clinical activities designed to stabilize the patient's mental health problems and psychiatric symptoms, and to maintain such stabilization. The goals of therapy apply to both the substance use disorder and any co-occurring mental disorder. Specific attention is given to medication education and management and to motivational and engagement strategies, which are used in	• Moderate to severe functional or developmental impairment in at least one area, • Risk of out of home placement or has had multiple transition in placement in the last 6 months due to symptoms of mental illness • Risk of school or daycare placement loss due to mental illness or development needs. • Multiple system involvement requiring coordination and case management • Moderate to severe behavioral issues that cause chronic family disruption • Transition from a higher level of service intensity (step-down) to maintain treatment gains • Child and/or family's level of English language skill and/or acculturation is not sufficient to achieve symptom or functional improvement without case management		

preference to non-evidence-based practices. **Treatment Plan Requirements:** Programs provide a review of the patient's recent psychiatric history and mental status examination. (If necessary, this review is conducted by a psychiatrist.) A comprehensive psychiatric history and examination and psychodiagnostic assessment are performed within a reasonable time, as determined by the patient's needs. Programs also provide active assessments of the patient's mental status, at a frequency determined by the urgency of the patient's psychiatric symptoms, and follow through with mental health treatment and psychotropic medications as indicated. **Initial authorization: 30 days**. All members are initially admitted to A&D Residential and the provider obtains the			

A&D residential authorization. Within two weeks, members are assessed for meeting criteria for the dual diagnosis program. Provider to submit Mental Health assessment and are provided with a Dual Diagnosis program authorization. **Concurrent authorization: 30 days**. Submit updated Mental Health ISSP and treatment plans and progress toward stated goals in the ISSP.			

Dual Diagnosis Residential Treatment - ASAM Level 3.5

Adult

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria

Support System Requirements:
Programs offer psychiatric services, medication evaluation and laboratory services. Such services are available by telephone within 8 hours and on-site or closely coordinated off-site within 24 hours, as appropriate to the severity and urgency of the patient's mental condition.
Staffing Requirements:
Programs are staffed by appropriately credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques.
Some (if not all) of the addiction treatment professionals should have sufficient cross-training to
	Must meet the following:
	• Covered mental health diagnosis on the prioritized list AND
	• At least one psychiatric hospitalization within the last 6 months OR
	• Extended or repeated crisis episode(s) requiring increased services AND
	• DSM-5 criteria
	  ○ Moderate or Severe Severity diagnosis
	  ○ Mild severity only if pregnant or high risk of medical/behavioral complication
	
	AND at least two of the following must be met:
	• Risk of harm to self or others or risk of harm to self or others that is escalated from baseline
	• Moderate functional impairment in at least two areas (such as housing,
		Continues to meet admission criteria AND at least one of the following:
		• Capable of additional symptom or functional improvement at this level of care
		• Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service
		• Active Care Coordination is occurring with mental health, substance use disorder, and primary care outpatient providers
			At least ONE of the following must be met:
			• Documented treatment goals and objectives have been substantially met
			• Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports
			• Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care
			• Meets criteria for a different level of care due to change in symptoms or function at this level of care or maximum therapeutic benefit has been met

understand the signs and symptoms of co-occurring mental disorders, and to understand and be able to explain to the patient the purposes of psychotropic medications and their interactions with substance use. The intensity of nursing care and observation is sufficient to meet the patient's needs. **Therapy Requirements:** Programs offer planned clinical activities designed to stabilize the patient's mental health problems and psychiatric symptoms, and to maintain such stabilization. The goals of therapy apply to both the substance use disorder and any co-occurring mental disorder. Specific attention is given to medication education and management and to motivational and engagement strategies, which are used in preference to non-evidence-based practices.	financial, social, occupational, health, activities of daily living.) • Multiple system involvement requiring coordination and case management • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses • Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports		

Treatment Plan Requirements: Programs provide a review of the patient's recent psychiatric history and mental status examination. (If necessary, this review is conducted by a psychiatrist.) A comprehensive psychiatric history and examination and psycho-diagnostic assessment are performed within a reasonable time, as determined by the patient's needs. Programs also provide active assessments of the patient's mental status, at a frequency determined by the urgency of the patient's psychiatric symptoms, and follow through with mental health treatment and psychotropic medications as indicated. **Initial authorization: 30 days**. All members are initially admitted to Substance Use Disorder Residential and the provider obtains the SUD residential authorization.			

Within two weeks, members are assessed for meeting criteria for the dual diagnosis program. Provider to submit Mental Health assessment and are provided with a Dual Diagnosis program authorization. **Concurrent authorization: 30 days**. Submit updated Mental Health ISSP and treatment plans and progress toward stated goals in the ISSP.			

Substance Use Disorder High Intensity Medically Monitored Residential - ASAM Level 3.7 Adult

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Support System Requirements: Physician (or NP, PA or PNP) assessment within 24 hours of admission and as medically necessary. RN to conduct alcohol or other drug focused nursing assessment at admission, monitoring progress and medication administration. Lab and toxicology service available on site, along with consultation, and/ or referral. Coordination of services with other levels of care are provided. Psychiatric services available within 8 hours by phone or 24 hours in person. Medical Director is an addiction specialized physician or psychiatrist OR a LPN w/CADC to meet biomedical enhanced service description. Behavioral health specialists dually trained CADC w/ specific behavioral	**Must meet the following criteria in two of the Dimensions with at least one of the criteria in Dimensions 1, 2 or 3:** Dimension 1: • Acute intoxication and/or withdrawal potential: High risk of withdrawal symptoms that can be managed in a Level 3.7 program. Dimension 2: • Biomedical conditions and complications: Moderate to severe conditions which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital. Dimension 3: • Emotional, behavioral, or cognitive conditions and complications: Moderate to severe conditions and complications (such as diagnosable co-morbid	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service • Active Care Coordination is occurring with mental health, substance use disorder, and primary care	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care or maximum therapeutic benefit has been met

health management techniques training and knowledge of evidence-based practices. **Staffing Requirements:** Interdisciplinary team of appropriately credentialed treatment professionals including addiction credentialed physician. Medical professional, nurses, addiction counselors, behavioral health specialists with ASAM specific knowledge, behavior management techniques and EBP use providing a planned regimen of 24 hour professionally directed evaluation, care and treatment services including administration of prescribed medications. **Therapy Requirements:** Co-occurring disorder treatment facility provides 30 hours of structured treatment activities per week including, but not limited to psychiatric and substance use assessments, diagnosis, treatment, and rehabilitation services. At least 10 of the 30 hours is to include individual, group, and/or family counseling. Target population for this LOC are participants with high risk of	mental disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms) and may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others. • Psychiatric symptoms are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts. Dimension 4: • Readiness to change: Participant unable to acknowledge the relationship between the addictive disorder and mental health and/or medical issues, or participant is in need of	outpatient providers	

withdrawal symptoms, moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require a 24-hour treatment LOC. All facilities are licensed by OHA. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour medically monitored treatment setting Full description is available by referring to The ASAM Criteria 3rd Edition **Initial authorization: 7 days** **Concurrent authorization: Up to 7 additional days**	intensive motivating strategies, activities, and processes available only in a 24-hour structured medically monitored setting (but not medically managed). Dimension 5: • Relapse, continued use, or continued problem potential: Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or re-emergence of acute symptoms and is in need of 24-hour monitoring and structured support. Dimension 6: • Recovery environment: Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level of care.		

Clinically Managed Withdrawal Management (Detox) – ASAM Level 3.2

Adult and Youth

Service Description

Clinically Managed Residential Withdrawal Management (Detox): Level 3.2-WM or "social setting detox," occurs in a freestanding residential setting and is an organized service that includes 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. This level is characterized by peer and social support rather than the medical and nursing care. Patients appropriate for this level of care do not require the full resources of a Level 3.7- WM Medically Monitored Inpatient Withdrawal Management program described below.

Since Level 3.2-WM is managed by clinical, not medical or nursing staff, protocols are in place should a patient's condition deteriorate and appear to need medical or nursing interventions. These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include under what conditions nursing and physician care is warranted and/or when transfers to a medically monitored facility or an acute care hospital is necessary. The protocols are developed and supported by a physician knowledgeable in addiction medicine.

Therapies offered by Level 3.2-WM withdrawal management programs include daily clinical services to assess and address the needs of each patient. Such clinical services may include appropriate medical services, individual and group therapies, and withdrawal support.

Withdrawal Management Services may be offered in any appropriate setting that meets state licensure or certification criteria, including OARs 415-050-000 through 415-050-0095.

Criteria for Authorization

Criteria for Clinically Managed Residential Withdrawal Management (Detox): To be appropriate for Clinically Managed Residential Withdrawal Management, the individual must meet the following conditions:

- The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent
- The patient is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service

- **Alcohol:** The patient is intoxicated or withdrawing from alcohol and the CIWA-Ar score is less than 8 at admission, and monitoring is available to assure that it remains less than 8, or the equivalent for a comparable standardized scoring system
- **Opioids:** Withdrawal signs and symptoms are distressing but do not require medication for reasonable withdrawal discomfort and the patient is impulsive and lacks skills needed to prevent immediate continued drug use
- **Stimulants:** The patient has marked lethargy, hypersomnolence, paranoia, or mild psychotic symptoms due to stimulant withdrawal, and these are still present beyond period of outpatient monitoring available in Level 2 WM services

Concurrent Review Criteria

It is appropriate to retain the patient at the present level of care if:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

or

- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

and/or

- New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. This level is the least intensive at which the patient's new problems can be addressed effectively

Transition/ Discharge Criteria

It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

- Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care;

or

- The patient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 3.7- WM or Level 4-WM intensive level of withdrawal management is indicated

Medically Monitored Withdrawal Management (Detox) – ASAM Level 3.7

Adult and Youth

Service Description

Medically Monitored Inpatient Withdrawal Management/ Detox: Level 3.7-WM or a "freestanding withdrawal management/ detox center" is an organized service delivered by medical and nursing professionals, which provides 24-hour evaluation and withdrawal management. Services are provided in a permanent, freestanding facility with inpatient beds that is not a Level 4-WM acute care inpatient hospital setting.

Therapies offered by Level 3.7-WM withdrawal management programs include daily clinical services to assess and address the needs of each patient. Such clinical services may include appropriate medical services, individual and group therapies, and withdrawal support. In addition, hourly nurse monitoring of the patient's progress and medication administration are available, if needed.

Withdrawal Management Services may be offered in any appropriate setting that meets state licensure or certification criteria, including OARs 415-050-000 through 415-050-0095.

Criteria for Authorization

Criteria for Medically Monitored Inpatient Withdrawal Management (Detox): To be appropriate for Medically Monitored Inpatient Withdrawal Management, the individual must meet the following conditions:

- The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavior, or cognitive condition) that a severe withdrawal syndrome is imminent.
- The severe withdrawal syndrome is assessed as manageable at this level of service.
    - **Alcohol:** The patient is withdrawing from alcohol, the CIWA-Ar score is 19 or greater (or the equivalent for a standardized scoring system) by the end of the period of outpatient monitoring available in Level 2-WM.
    - **Alcohol and Sedative/Hypnotics:** The patient has marked lethargy or hypersomnolence due to intoxication with alcohol or other drugs, and a history of severe withdrawal syndrome, or the patient's altered level of consciousness has not stabilized at the end of the period of outpatient monitoring available at Level 2-WM.
    - **Sedative/Hypnotics:** The patient has ingested sedative/hypnotics at more than therapeutic levels daily for more than 4 weeks and is not responsive to appropriate recent efforts to maintain the dose at therapeutic levels.

- The patient has ingested sedative/hypnotics at more than therapeutic levels daily for more than 4 weeks, in combination with daily alcohol use or regular use of another mind-altering drug known to pose a severe risk of withdrawal. Signs and symptoms of withdrawal are of moderate severity, and the patient cannot be stabilized by the end of the period of outpatient monitoring available at Level 2 WM
    - **Alcohol and Sedative/Hypnotics:** The patient has marked lethargy or hypersomnolence due to intoxication with alcohol or other drugs, and a history of severe withdrawal syndrome, or the patient's altered level of consciousness has not stabilized at the end of the period of outpatient monitoring available at Level 2-WM
    - **Opioids:** For withdrawal management not using opioid agonist medication: The patient has used Opioids daily for more than 2 weeks and has a history of inability to complete withdrawal as an outpatient or without medication in a Level 3.2-WM service. Antagonist medication is to be used in withdrawal in a brief but intensive withdrawal management (as in multiday pharmacological induction onto naltrexone)
    - **Stimulants:** The patient has marked lethargy, hypersomnolence, agitation, paranoia, depression, or mild psychotic symptoms due to stimulant withdrawal, and has poor impulse control and/or coping skills to prevent immediate continued drug use

Concurrent Review Criteria

It is appropriate to retain the patient at the present level of care if:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

or

- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

and/or

- New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. This level is the least intensive at which the patient's new problems can be addressed effectively

Transition/ Discharge Criteria
It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria: • Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; **or** • The patient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 4-WM intensive level of withdrawal management in a hospital is indicated

Transcranial Magnetic Stimulation

Adult

Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/ Discharge Criteria
Transcranial Magnetic Stimulation (TMS) is an exceptional needs treatment intervention considered only after various trials of different therapies and medications, of various classes, have been exhausted. TMS is generally used as a secondary treatment when the individual has not responded to medication and/or psychotherapy. The TMS treatment is delivered by a device that is FDA-approved or FDA-cleared for the treatment of MDD in a safe and effective manner. The decision to administer TMS must be based on an evaluation of the risks and benefits involving a combination of factors that include psychiatric diagnosis, type and severity of symptoms, prior treatment history and response, and identification of possible alternative treatment options.	**To be considered for a TMS assessment, the individual must meet *All* the following criteria:** • Must be 18 years or older • Major Depressive Disorder (MDD), severe degree without psychotic features • Must demonstrate resistance to treatment as evidenced by a lack of clinically significant response to 4 trials of psychopharmacological agents from at least two different agent classes, at or above the minimum effective dose and duration, and trials of at least two evidence-based augmentation therapies. • The member has had a trial of evidence-based	TMS is generally authorized 5 treatments per week for 6 weeks. Up to 6 taper treatments over three weeks may be authorized. The maximum duration of treatment is 9 weeks regardless of missed or skipped treatments. **Additional sessions may be authorized in the following circumstances:** • Persistence of symptoms with improvement but where maximum benefit has not been achieved **OR** • New symptoms or problems that meet clinical criteria for TMS have emerged.	**Discharge criteria: *Any* of the following are sufficient for discharge from this level of care:** • Individual has achieved adequate stabilization of the depressive symptoms. • Individual no longer meets admission criteria, or meets criteria for a less or more intensive services. • Individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful measurement improvement. • Worsening of depressive symptoms such as increased suicidal thoughts/behaviors or unusual behaviors. • Member has completed the course of 5 treatments per week for 6 weeks and up to 6 taper treatments over

A request for an assessment must be made in writing by the prescriber (either a licensed psychiatrist or psych nurse practitioner) to the assigned Behavioral Health Plan Partner (BHPP)). BHPP Medical Directors will determine whether or not criteria are met for an assessment to be covered by a TMS provider. The order for treatment must be written by a physician who is board certified and who must have experience in administering TMS therapy and must certify that the treatment will be given under direct supervision of this physician. ***Any* of the following criteria are sufficient for exclusion from this level of care:** • The individual has medical conditions or impairments that would prevent beneficial utilization of the services • The individual requires 24-hour medical/nursing monitoring or procedures provided in a hospital setting. • Younger than 18 years of age or older than 70 years of age.	psychotherapy known to be effective treatment of MDD of an adequate frequency and minimum of 12 weeks duration without significant improvement in depressive symptoms as documented by standard rating scales. • A history of clinical response to TMS in a previous depressive episode. • Client must voluntarily agree to TMS assessment		three weeks (maximum duration of treatment is 9 weeks regardless of missed/skipped treatments). • Provider has failed to monitor, document, and or report member response to treatment.

• Patients with recent history of active substance abuse, obsessive compulsive disorder, or posttraumatic stress disorder. • Patients with a psychotic disorder, including schizoaffective disorder, bipolar disorder, or MDD with psychotic features. • Patients with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS. • The presence of metal or conductive device in the head or body that is contraindicated with TMS. • Patients with MDD who have failed to receive clinical benefit from ECT or VNS. • Presence of severe cardiovascular disease. • Patients who are pregnant or nursing. • TMS is not indicated for maintenance treatment.			