Beacon Health Options

National Medical Necessity/Level of Care Criteria

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

Medically Necessary Services are defined as those that are:

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

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

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

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NMNC 1.101.02 Inpatient Psychiatric Services

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Must have all criteria #1-4 and either 5 or 6; criteria 7 and 8 as applicable for Eating Disorders 9-11 must also be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis 2) Member's psychiatric condition requires 24-hour medical / psychiatric and nursing services and of such intensity that needed services can only be provided in an acute psychiatric hospital. 3) Inpatient psychiatric services are expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical / psychiatric and nursing services will no longer be needed. 4) Symptoms do not result from a medical condition that would be more appropriately treated on a medical/surgical unit. 5) One of the following must also be present: a. Danger to self. 6) A serious suicide attempt by degree of lethality and intentionality, suicidal ideation with plan and means: a. Available and/or history of prior serious suicide attempt; b. Suicidal ideation accompanied by severely depressed mood, significant losses, and/or continued intent to harm self; c. Command hallucinations or persecutory delusions directing self-harm; d. Loss of impulse control resulting in life - threatening behavior or danger to self; e. Significant weight loss within the past three months;	**Criteria 1 - 10 must be met; For Eating Disorders, criterion 11 or 12 must be met:** 1) Member continues to meet admission criteria; 2) Another less restrictive Level of Care would not be adequate to administer care. 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require rapid re-hospitalization; 4) Treatment is still necessary to reduce symptoms and improve functioning so that the member may be treated in a less restrictive Level of Care. 5) There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment continuing in a less restrictive Level of Care; 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. Treatment plan has been updated to address non-adherence. 7) The member is actively participating in plan of care and treatment to the extent possible consistent with his/her condition 8) Family/guardian/caregiver is participating in treatment as appropriate.	**Any one of the following: Criteria 1, 2, 3, or 4; criteria 5 and 6 are recommended, but optional. For Eating Disorders, criteria 8 - 10 must be met:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment and/or member does not meet criteria for involuntary or mandated treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is aware and in agreement with the aftercare treatment plan. 7) Member's physical condition necessitates transfer to a medical facility. ***For Eating Disorders:**

f. Self-mutilation that could lead to permanent disability; g. Uncontrolled risk taking behaviors h. Danger to others: i. Homicidal ideation and/or indication of actual or potential danger to others; 1. Command hallucinations or persecutory delusions directing harm or potential violence to others; 2. Indication of danger to property evidenced by credible threats of destructive acts 3. Documented or recent history of violent, dangerous, and destructive acts 7) Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning; 8) Evidence of severe disorders of cognition, memory, or judgment are not associated with a primary diagnosis of dementia or other cognitive disorder (e.g. acute psychotic symptoms). 9) Severe comorbid substance use disorder is present and must be controlled (e.g. abstinence necessary) to achieve stabilization of primary psychiatric disorder ***For Eating Disorders** ***weight alone should not be the sole indicator of admission or discharge** 10) DSM or corresponding ICD diagnosis and symptoms consistent with a primary diagnosis of Eating Disorder 11) Member has at least one of the following: a. Psychiatric, behavioral, and eating disorder symptoms that are expected to respond to treatment in an Acute Level of Care b. Symptomatology that is not responsive to treatment in a less intensive Level of Care. c. An adolescent with newly diagnosed anorexia;	9) There is documentation of coordination of treatment with state or other community agencies, if involved. 10) Coordination of care and active discharge planning are ongoing, beginning at admission, with goal of transitioning the member to a less intensive Level of Care. ***For Eating Disorders**: 11) Member has had no appreciable weight gain (<2lbs/wk.) 12) Ongoing medical or refeeding complications.	8) Member has reached at least 85% ideal body weight and has gained enough weight to achieve medical stability (e.g., vital signs, electrolytes, and electrocardiogram are stable). 9) No re-feeding is necessary 10) All other psychiatric disorders are stable.

12) Member requires 24-hour monitoring, which includes: before, after, and during meals; evening to monitor behaviors (i.e. restricting, binging/purging, over-exercising, use of laxatives or diuretics);

13) Member exhibits physiological instability requiring 24-hour monitoring for at least **one (1) of the following**:

- a. Rapid, life-threatening and volitional weight loss not related to a medical illness: generally, <80% of IBW (or BMI of 15 or less. Electrolyte imbalance (i.e. Potassium <3)
- b. Physiological liability (i.e. Significant postural hypotension, bradycardia, CHF, cardiac arrhythmia);
- c. Change in mental status;
- d. Body temperature below 96.8 degrees;
- e. Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement;
- f. Acute gastrointestinal dysfunction (i.e. Esophageal tear secondary to vomiting, mega colon or colonic damage, self- administered enemas);
- g. Heart rate is less than 40 beats per minute for adults or near 40 beats per minute for children

Exclusions

Any *of the following criteria is sufficient for exclusion from this level of care*

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

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NMNC 1.102.02 Observation Behavioral Health Service Observation (OBS) Beds allow time for extended assessment for observation in a secure, medically staffed, and psychiatrically monitored setting. The objective of this setting is for prompt evaluation and stabilization services that will likely result in a referral to a less intensive setting, or provides a safe environment to obtain additional information about the member's condition in order to obtain a referral to a more appropriate setting (more or less intensive). This level of care is generally used for a duration of 24 hours or less, though may be extended as required, for a maximum of 72 hours		
Admission Criteria	**Continued Stay Criteria**	**Discharge Criteria**
All of the following criteria must be met: 1) Symptoms consistent with a DSM or corresponding ICD Diagnosis; 2) Indication that the symptoms may stabilize within a 23-72 hour period at which time a less restrictive level of care will be appropriate; 3) One of the following must be present: a) Indication of actual or potential danger to self or others as evidenced by: 1. Suicidal intent or recent attempt with continued intent; 2. Homicidal ideation; 3. Command hallucinations or delusions; b) Loss of impulse control leading to life- threatening behavior and/or psychiatric symptoms that require immediate stabilization in a structured, psychiatrically monitored setting; c) Substance intoxication with d) suicidal/homicidal ideation or inability to care for self; e) Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning; 4) Presenting crisis cannot be safely evaluated or managed in a less restrictive setting; 5) Member is willing to participate in treatment voluntarily. **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care* 1) The individual can be safely maintained and effectively treated at a less restrictive level of care.	**All of the following criteria must be met:** 1) Member continues to meet admission criteria; 2) Another less restrictive level of care would not be adequate to provide needed containment and administer care; 3) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care. 4) There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment continuing in a less restrictive level of care; 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Family / guardian / caregiver is participating in treatment as clinically indicated, or engagement efforts are underway. 7) Coordination of care and active discharge planning includes goal of transitioning the member to a less intensive level of care or transferring the member to a higher level of care.	**Any one of the following: Criteria #1, 2, 3, or 4: Criteria # 5 and 6 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment *and* member does not meet criteria for involuntary/mandated treatment. 3) Member does not appear to be participating in the treatment plan 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

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2) Threat or assault toward others is not accompanied by a DSM or corresponding ICD diagnosis amenable to acute treatment. 3) Presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care. 4) The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting the criteria for this level of care. 5) Admission is being used as an alternative to incarceration.		

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NMNC 2.201.02 Crisis Stabilization

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

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

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3) The individual does not voluntarily consent to admission or treatment (unless being used as an alternative to an inpatient level of care). 4) The individual can be safely maintained and effectively treated in a less intensive level of care. 5) Request for service is not being pursued to address a primary issue of homelessness or lack of identified disposition. 6) Admission is being used as an alternative to incarceration.	goal of transitioning the member to a less intensive Level of Care.	

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NMNC 2.202.0 Residential Treatment Services (RTS) Residential Treatment Services (also known as a Residential Treatment Center) are 24-hours, 7 days a week facility-based programs that provide individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming, such as group, CBT, DBT and motivational interviewing, within a milieu with a high degree of supervision and structure and is intended for members who does not need the high level of physical security and frequency of psychiatric or medical intervention that are available on an inpatient unit. In addition, the program provides individualized therapeutic treatment. RTS is not an equivalent for long-term hospital care, rather, its design is to maintain the member in the least restrictive environment to allow for stabilization and integration. Consultations and psychological testing, as well as routine medical care, are included in the per diem rate. RTS's serve members who have sufficient potential to respond to active treatment, need a protected and structured environment, and for whom outpatient, partial hospitalization, or acute hospital inpatient treatments are not appropriate. days. Realistic discharge goals should be set upon admission, and full participation in treatment by the member and his or her family members, as well as community-based treatment providers is expected when appropriate.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 – 9 must be met for all; Criteria 10, when applicable. For Eating Disorders, criteria 11-15 must also be met: 1) DSM or corresponding ICD diagnosis and must have a mood, thought, or behavior disorder which requires, and can reasonably be expected to respond to therapeutic interventions 2) The Member is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured24-hour therapeutic setting. 3) The member may not be appropriate for a different level of care as evidenced by a series of increasingly dangerous behaviors which present significant risk 4) Member has sufficient cognitive capacity to respond to active acute and time-limited psychological treatment and intervention. 5) Severe deficit in ability to perform self-care activity is present (i.e. self-neglect with inability to provide for self at a lower level of care). 6) Member has only poor to fair community supports sufficient to maintain him/her within the community with treatment at a lower level of care. 7) Member requires a time-limited period for stabilization and community reintegration. 8) When appropriate, family/guardian/ caregiver agree to participate actively in treatment as a condition of admission. 9) Member's behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment.	**Criteria 1 – 11 must be met for all; For Eating Disorders criteria 12 and 13 must be met:** 1) Member continues to meet admission criteria; 2) Another less restrictive level of care would not be adequate to provide needed containment and administration of care. 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely be readmitted; 4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care. 5) There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment in a less restrictive level of care 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out 7) Member evaluation by physician occurs on an at least weekly basis 8) Member's progress is monitored regularly and the treatment plan is modified, if the member is not making	**Criteria 1, 2, 3, or 4 are suitable; criteria 5 and 6 are recommended, but optional; For Eating Disorders, criterion 7 must be met:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, more or less intensive. 2) Member or parent/guardian withdraws consent for treatment and the member does not meet criteria for involuntary/mandated treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan. **For Eating Disorders** 7) Member has gained weight, is in better control of weight reducing behaviors/actions, and can now be

10) Severe comorbid substance use disorder is present that must be controlled (e.g., abstinence necessary) to achieve stabilization of primary psychiatric disorder. **For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge** 11) Weight stabilization: generally, <85% of IBW (or BMI of 15 or less, with no significant co-existing medical conditions (see IP #14) 12) Member is medically stable and does not require IV fluids, tube feedings or daily lab tests. 13) Member has had a recent significant weight loss and cannot be stabilized in a less restrictive level of care. 14) Member needs direct supervision at all meals and may require bathroom supervision for a time period after each meal. 15) The member is unable to control obsessive thoughts or reduce negative behaviors (e. g. restrictive eating, purging, laxative or diet pill abuse, and/or excessive exercising) in a less restrictive environment. **Exclusions:** ***Any** of the following criteria is sufficient for exclusion from this level of care:* 1) Member's IBW is < 75% (or BMI of 14 or less) 2) The individual exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care. 3) The individual does not voluntarily consent to admission or treatment. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 5) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 6) The primary problem is social, legal, and economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as custodial care or as an alternative to incarceration.	progress towards a set of clearly defined and measurable goals. 9) Member is engaged in treatment and amenable to goals / interventions set forth by treatment team. 10) Family / guardian / caregiver is participating in treatment as clinically indicated and appropriate or engagement is underway. 11) There must be evidence of coordination of care and active discharge planning to: a. Transition the member to a less intensive level of care; b. Operationalize how treatment gains will be transferred to subsequent level of care. **For Eating Disorders:** 12) Member continues to need supervision for most if not all meals and/or use of bathroom after meals. 13) Member has had no appreciable weight gain since admission.	safely and effectively managed in a less intensive level of care.

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NMNC 2.203.01 Group Home

Group Homes provide 24-hour services in licensed, non-secure facilities. A community-based therapeutic group home is designed for members with significant deficits in independent living skills. Group Homes offer a less restrictive treatment environment than a residential treatment center but are more restrictive than day treatment or outpatient services. Comprehensive services focus on rehabilitation and include multidisciplinary, multimodal therapies to fit the need of the resident. Medical and nursing services are generally available on a consultative basis. Typically, coordinated treatment services include individual, group, family counseling, rehabilitation, vocational training, and skill building. Active family/significant other involvement is important unless contraindicated and should occur based on individual needs. Individuals may go into the community for work, school, and/or outside activities. Community resources are used in a planned, purposeful, and therapeutic manner that is recovery focused and encourages autonomy for a successful transition back into the community.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis. 2) Member is not sufficiently stable to be treated outside of a supervised 24-hour therapeutic environment. 3) Member demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, independent or semi-independent life skills development, and medication compliance training such that independent living is a realistic goal. 4) Member is able to function with some independence and participate in community based activities for limited periods of time that are structured to develop skills for functioning outside of a controlled psychiatric environment. 5) Member lacks community supports sufficient to maintain him/her in the community with treatment at a lower level of care. For children/adolescents the family situation and functioning levels are such that the member cannot safely remain with his/her biological, adoptive or guardian family. **Exclusions:** ***Any*** *of the following criteria is sufficient for exclusion from this level of care:* 1) The individual is a danger to self and others or sufficient impairment exists that a more intensive level of service is required.	**All of the following criteria must be met:** 1) Member continues to meet admission criteria. 2) Another less intensive level of care would not be adequate to administer care; 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require a more intensive level of care. 4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less intensive level of care; 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress towards clearly defined and measurable goals; 7) Family/guardian/caregiver is participating in treatment as appropriate. 8) There is documentation around coordination of treatment with all involved parties including state/community agencies when appropriate; 9) The provider has documentation supporting discharge planning attempts to transition the member to a less intensive level of care.	**Any one of the following:** **Criteria 1,2,3, or 4; criteria 5 and 6 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

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2) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 3) The individual requires a level of structure and supervision beyond the scope of the program. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 5) The primary problem is social, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.		

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NMNC 3.301.02 Partial Hospitalization Program

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 - 8 must be met; For Eating Disorders, criteria 9 – 10 must also be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis; 2) The member manifests a significant or profound impairment in daily functioning due to psychiatric illness. 3) Member has adequate behavioral control and is assessed not to be an immediate danger to self or others requiring 24-hour containment or medical supervision. 4) Member has a community-based network of support and/or parents/caretakers who are able to ensure member's safety outside the treatment hours. 5) Member requires access to a structured treatment program with an on-site multidisciplinary team, including routine psychiatric interventions for medication management. 6) Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize their condition. 7) The severity of the presenting symptoms is not able to be treated safely or adequately in a less intensive level of care. 8) Member has adequate motivation to recover in the structure of an ambulatory treatment program. **For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge** 9) Member requires admission for Eating Disorder Treatment and requires at least one of the following:	**Criteria 1 - 7 must be met; For Eating Disorders, criterion 8 must also be met:** 1) Member continues to meet admission criteria; 2) Another less intensive level of care would not be adequate to administer care. 3) Treatment is still necessary to reduce symptoms and increase functioning so the member may be treated in a less intensive level of care. 4) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 7) Coordination of care and active discharge planning are ongoing, with	**Any one of the following: Criteria 1, 2, 3, or 4; criteria 5 and 6 are recommended, but optional; For Eating Disorders, criterion 7 is also appropriate:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or parent / guardian withdraws consent for treatment. 3) Member does not appear to be participating in treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support systems are in agreement with the aftercare treatment plan. **For Eating Disorders**: 7) Member has been adherent to the Eating Disorder related protocols, medical status is stable and appropriate, and the member can now be managed in a less intensive level of care.

a) Weight stabilization: generally, between 80 and 85% of IBW (or BMI 15-17) with no significant co- existing medical conditions (see IP #14) b) Continued monitoring of corresponding medical symptoms; c) Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning. 10) Any monitoring of member's condition when away from partial hospital program can be provided by family, caregivers, or other available resources. **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required. 2) The individual does not voluntarily consent to admission or treatment or does not meet criteria for involuntary admission to this level of care. 3) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 4) The individual exhibits a serious and persistent mental illness consistent throughout time **and** is not in an acute exacerbation of the mental illness. 5) The individual requires a level of structure and supervision beyond the scope of the program (i.e. considered a high risk for non-compliant behavior and/or elopement). 6) The individual can be safely maintained and effectively treated at a less intensive level of care.	goal of transitioning member to a less intensive Level of Care. **For Eating Disorders:** 8) Member has had no appreciable stabilization of weight since admission; 9) Other eating disorder behaviors persist and continue to put the member's medical status in jeopardy.	

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NMNC 3.302.2 Intensive Outpatient Treatment

Intensive outpatient programs (IOP) offer short-term, multidisciplinary, structured day or evening programming that consists of intensive treatment and stabilization within an outpatient therapeutic milieu setting. IOP must be available at least 3 - 5 days per week. . Treatment reduces in intensity and frequency as the member establishes community supports and resumes daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long term day treatment. IOPs may be provided by either hospital- based or freestanding outpatient programs to members who experience symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive level of care. These programs also include 24/7 crisis management services, individual, group, and family therapy and coordination of medication evaluation and management services, as needed. Coordination with collateral contacts and care management/discharge planning services should also occur regularly as needed in an IOP. For **children and adolescents**, the IOP provides services similar to an acute level of care for those members with a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child's caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

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

For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge 9) Member requires admission for Eating Disorder Treatment and requires at least one of the following: a) Weight stabilization: generally, between 80 and 85% of IBW (or BMI of 15-17 or more) with no significant co- existing medical conditions (see IP #14) b) Continued monitoring of corresponding medical symptoms; c) Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning. 10) Any monitoring of member's condition when away from intensive outpatient program can be provided by family, caregivers, or other available resources. **Exclusions:** ***Any*** *of the following criteria is sufficient for exclusion from this level of care:* 1) The individual is a danger to self and others or sufficient impairment exists that a more intensive level of service is required. 2) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 3) The individual requires a level of structure and supervision beyond the scope of the program. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 5) The primary problem is social, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration. 6) 6) The main purpose of the admission is to provide structure that may otherwise be achieved via		

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community based or other services to augment vocational, therapeutic or social activities.		

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NMNC 3.303.2 Day Treatment

Day treatment services assist individuals in beginning the recovery and rehabilitative process, providing supportive, transitional services to members that are no longer acutely ill, but still require moderate supervision to avoid risk and/or continue to re-integrate into the community or workforce. These programs must be available a minimum of 4 days per week This structured, activity-based setting is ideal for members that continue to have significant residual symptoms requiring extended therapeutic interventions. Day treatment is focused on the development of a member's independent living skills, social skills, self-care, management of illness, life, work, and community participation, thus maintaining or enhancing current levels of functioning and skills. Members participating in treatment have access to crisis management, individual group, family therapy, and coordination with collateral contacts as clinically indicated. Treatment declines in intensity as members develop skills and attain specific goals within a reasonable time frame allowing the transition to an outpatient setting with other necessary supports and longer-term supportive programming (i.e. clubhouse, employment, school, etc.).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria 1-7 must be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis. 2) Member's exacerbation or longstanding psychiatric disorder and level of functioning requires daily support and structure; 3) The member has the motivation and capacity to participate and benefit from day treatment. 4) Treatment at a less intensive level of care would contribute to an exacerbation of symptoms. 5) Member is assessed to be at risk of requiring a higher level of care if not engaged in day treatment services. 6) Member / guardian is willing to participate in treatment voluntarily. 7) Member's psychiatric / substance use / biomedical condition is sufficiently stable to be managed in a day treatment setting. **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required. 2) The individual can be safely maintained and effectively treated at a less intensive level of care.	**All of the following criteria 1-7 must be met:** 1) Member continues to meet admission criteria. 2) Another less intensive level of care would not be adequate to administer care. 3) Treatment is still necessary to reduce symptoms and increase functioning for the member to be transitioned to a less restrictive setting. 4) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5) Family/guardian is participating in treatment as clinically indicated. 6) Coordination of care and active discharge planning are ongoing. 7) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress towards clearly defined and manageable goals	**Any one of the following: Criteria 1,2,3, or 4; criteria 5 and 6 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment program.

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3) The individual does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment. 4) The individual requires a level of structure and supervision beyond the scope of the program. 5) The individual has medical conditions or impairments that would prevent beneficial utilization of services or is not stabilized on medications. 6) The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.		

NMNC 4.401.2 Mobile Crisis

Mobile Crisis provides on-site mobile assessment and crisis intervention to members in an active state of crisis. The purpose of Mobile Crisis is to provide rapid response, assessment, and early intervention for adults, children/adolescents and families in crisis. This service is provided 24 hours a day, 7 days a week, and should include a crisis assessment and the development of a risk management/safety plan. Referrals and coordination of services are provided to link members and their families to other service providers and community supports to assist with maintaining the member's functioning and treatment in the least restrictive, appropriate setting along the behavioral health continuum of care. Mobile Crisis will coordinate with the member's community providers, primary care physician, behavioral health providers, and any other care management program providing services to the youth or adult throughout the course of the service being provided.

Member's inability to participate in the assessment may result in referral/admission to a higher level of care

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria 1-6 must be met: 1) Member must be in an active state of crisis that has not been able to be resolved by phone or other community interventions; 2) Member must be able to vocalize and participate in planning; 3) Immediate intervention is necessary to attempt to stabilize member's condition safely; 4) Situation does not require an immediate public safety response. 5) The intervention is expected to improve the member's condition/stabilize the member in the community; 6) The member demonstrates at least one of the following: a) Suicidal/ assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others; ***or*** b) Impairment in mood/thought/behavior disruptive to home, school, or the community; c) Behavior is escalating to the extent that a higher intensity of services will likely be required without intervention.	**N/A**	**All of the following criteria 1-4 must be met:** 1) Crisis assessment and other relevant information indicate that member needs another level of care, either more or less intensive. 2) The Individual is released or transferred to an appropriate treatment setting based on crisis screening, evaluation, and resolution. 3) Member's physical condition necessitates transfer to an inpatient medical facility and the provider has communicated member risk management/safety plan to the receiving provider. 4) Consent for treatment is withdrawn.

NMNC 5.501.02 Outpatient Professional Services

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All criteria 1-8 must be met: 1) Member demonstrates symptoms consistent with a DSM or corresponding ICD diagnosis, and treatment focus is to stabilize these symptoms; 2) Member must be experiencing at least one of the following: a. A chronic affective illness, schizophrenia, or a refractory behavioral disorder, which by history, has required hospitalization or b. Moderate to severe symptomatic distress or impairment in functioning due to psychiatric symptoms in at least one area of functioning (i.e. self-care, occupational, school, or social function). 3) There is an expectation that the individual: a. Has the capacity to make significant progress towards treatment goals; b. Requires treatment to maintain current level of functioning; c. Has the ability to reasonably respond and participate in therapeutic intervention.	**All of the following criteria 1-10 must be met:** 1) Member continues to meet admission criteria. 2) Member does not require a more intensive level or care, and no less intensive level of care would be appropriate to meet the member's needs. 3) Evidence suggests that the identified problems are likely to respond to current treatment plan; 4) Member's progress is monitored regularly, and the treatment plan is modified, if member is not making substantial progress toward a set of clearly defined and measurable goals. 5) Treatment planning includes family or other support systems unless not clinically indicated. 6) The treatment plan is tailored to address the individual needs of the member: based upon assessment and reassessment throughout treatment, informed by objective outcome measurements (e.g. rating scales) that assess the member's response to treatment. The treatment plan is modified based on member's progress in or response to care. 7) Frequency and intensity of treatment contact occurs at a rate that is appropriate to the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal); and a lower frequency of sessions not would be sufficient to meet the member's needs.	**Criteria 1 and any one of 2 - 10 must be met:** 1) the precipitating factors leading to admission have been resolved or ameliorated such that the member no longer needs care. 2) Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others. 3) Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care. 4) Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment). 5) Member is competent and non-participatory in treatment, or the individual's non- participation is of such degree that treatment at this level of care is rendered ineffective or unsafe despite multiple

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d. Would be at risk to regress and require a more intensive level of care
4) The member does not require a more intensive level of structure beyond the scope of non-programmatic outpatient services.
5) Medication management is not sufficient to stabilize or maintain member's current functioning;
6) The member is likely to benefit from and respond to psychotherapy due to diagnosis, history, or previous response to treatment;
7) The member cannot be adequately stabilized in a rehabilitative, or community, service setting to assist with: health, social, occupational, economic, or educational issues.
8) Treatment is not being sought as an alternative to incarceration.

Exclusions:
Any of the following criteria are sufficient for exclusion from this level of care:

1) The individual requires a level of structure and supervision beyond the scope of non-programmatic outpatient services
2) The individual has medical conditions or impairments that would prevent beneficial utilization of services
3) The primary problem is social, occupational, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
4) Treatment plan is designed to address goals other than the treatment of active symptoms of DSM or corresponding ICD diagnosis (e.g. self- actualization).
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8) Evidence exists that member is at current risk of a higher level of care if treatment is discontinued.
9) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner.
10) There is documented active discharge planning from the beginning of treatment.
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documented attempts to address non-participation issues.
6) Evidence does not suggest that the defined problems are likely to respond to continued outpatient treatment.
7) Member is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment approach.
8) Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives.
9) Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for inpatient level of care.
10) It is reasonably predicted that maintaining stabilization can occur with discharge from care and/or Medication Management only and community support.
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5) Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in resuming prior level of roles and responsibility. 6) Treatment is primarily for the purpose of supportive, respite, social, custodial care.		

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NMNC 5.502.02 Psychological and Neuropsychological Testing

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

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

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

Admission Criteria	Criteria for Tests	Non-Reimbursable Tests
The following criteria must apply: **Psychological Testing 1-3 must be met:** 1) Request for testing is based on need for at least one of the following: a. Differential diagnosis of mental health condition unable to be completed by traditional assessment; b. Diagnostic clarification due to a recent change in mental status for appropriate level of care determination / treatment needs due to lack of standard treatment response. 2) Repeat testing needed as indicated by **ALL** of the following	1) Tests must be published, valid, and in general use as evidenced by their presence in the current edition of Tests in Print IX, or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association. 2) Tests are administered individually and are tailored to the specific diagnostic questions of concern.	1) Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., *MMPI* or *PIC)* as a general rule. 2) Group forms of intelligence tests. 3) Short form, abbreviated, or "quick" intelligence tests administered at the same time as the *Wechsler* or *Stanford-Binet* tests.

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a. Proposed repeat psychological testing can help answer question that medical, neurologic, or psychiatric evaluation, diagnostic testing, observation in therapy, or other assessment cannot.
b. Results of proposed testing are judged to be likely to affect care or treatment of member (i.e. contribute substantially to decision of need for or modification to a rehabilitation or treatment plan).
c. Member is able to participate as needed such that proposed testing is likely to be feasible (i.e. appropriate mental status, intellectual abilities, language skills).
d. No active substance use, withdrawal, or recovery from recent chronic use and
e. Clinical situation appropriate for repeat testing as indicated by **1 or more** of the following:
    - Clinically significant change in member's status (i.e., worsening or new symptoms or findings)
    - Other need for interval reassessment that will inform treatment plan

3) The member must have:
    a. Diagnostic evaluation (including psychosocial functioning), unless subject to state regulation or account-specific arrangements.
    b. No active withdrawal and/or substance misuse within 2 months of request
4) The member is experiencing cognitive impairments;

Exclusions:
Any *of the following criteria are sufficient for exclusion from this level of care:*

1) Testing is primarily to guide the titration of medication.
2) Testing is primarily for legal purposes, unless specified by state regulations or account-specific arrangements.
3) Testing is primarily for medical guidance, cognitive rehabilitation, or vocational guidance, as opposed to the **admission criteria** purposes stated above.
4) A repetition of any psychological test or tests provided to the same member within the preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes:
    a. Following such special forms of treatment or intervention such as ECT;
    b. Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions.
5) Tests for adults that fall in the educational arena or in the domain of learning disabilities.
6) Testing that is mandated by the courts, Department of Children's Services or other social/legal agency in the absence of a clear clinical rationale.
7) **Please Note:** Beacon will *not* authorize periodic testing to measure the member's response to psychotherapy.

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4) Testing request appears more routine than medically necessary (i.e. a standard test battery administered to all new members). 5) Interpretation and supervision of neuropsychological testing (excluding the administration of tests) is performed by someone other than a licensed psychologist or other clinician whom neuropsychological testing falls within the scope of their clinical license, and who has had special training in neuropsychological testing. 6) Measures proposed have no standardized norms or documented validity. 7) The time requested for a test/test battery falls outside Beacon Health Options established time parameters. 8) Extended testing for ADHD has been requested prior to provision of a thorough evaluation, which has included a developmental history of symptoms and administration of rating scales. 9) Symptoms of acute psychosis, confusion, disorientation, etc., interfering with proposed testing validity are present. 10) Administration, scoring and/or reporting of projective testing is performed by someone other than a licensed psychologist, or other clinician for whom psychological testing falls within the scope of their clinical licensure and who has specialized training in psychological testing.		

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NMNC 5.503.01 Biofeedback

Biofeedback is a process that enables an individual to learn how to change physiological activity for the purpose of improving health and performance. Precise instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity and skin temperature. These instruments rapidly and accurately "feedback" information to the user. The presentation of this information – often in conjunction with changes in thinking emotions and behavior – supports desired physiological changes. Over time these changes can endure without continued use of an instrument. (Association for Applied Psychophysiology and Biofeedback, 2008).

Although all treatment approval is subject to the general admission and exclusion criteria delineated below, the following are guidelines regarding the most common issues:

- Biofeedback has been used to treat children and adults with a wide variety of medical and behavioral health issues. Biofeedback is used for medical conditions including but not limited to: fecal incontinence, irritable bowel syndrome, chronic constipation, migraines, and adjunctive treatment for Raynaud's disease, tension headaches, pain and neuromuscular rehabilitation after a stroke or traumatic brain injury. Behavioral health conditions may include ADHD, Anxiety and Autism.
- Treatment of medical conditions may or may not be covered under the member's physical health coverage. Requests for these disorders should be directed to the medical carrier. Coverage may be determined under the mixed services protocol defining coverage of specific services.
- Biofeedback is typically performed in the outpatient office setting and is usually not used as a stand-alone treatment, but used adjunctively to other therapies including psychotherapy and medication. There is no current required separate certification in Biofeedback however there are certification entities (i.e. Biofeedback Certification International Alliance).
- Biofeedback may or may not be a covered benefit. If Biofeedback is not covered, an administrative determination of non-coverage will be rendered. The current determination by Beacon Health Options is that Biofeedback does not currently meet the criteria for inclusion as an evidence-based treatment for behavioral health disorders. The treatment of Anxiety Disorders, however, has the most supporting evidence for the treatment of behavioral health disorders. Application of these criteria is contingent on biofeedback being a covered benefit/non-excluded from a state or client specific contract.
- If Biofeedback is specifically included as a covered benefit and the request is for the treatment of an Anxiety Disorder, these criteria are to be used.
- If Biofeedback is specifically included as a covered benefit and the request is for any other diagnosis than an Anxiety Disorder, the specific diagnosis must be included under the Biofeedback coverage document for these medical necessity criteria to be used. If the particular diagnosis is not specifically covered, an administrative determination of non-coverage should be rendered (unproven for that diagnosis).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria 1 – 3 are necessary: 1) Biofeedback is a listed covered benefit with no specific included diagnoses and is being requested for the treatment of an Anxiety Disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)and can be reasonably expected to respond to this	**All of the following criteria 1-10 must apply:** 1) The individual continues to meet admission criteria for Biofeedback. 2) The individual does not require a more intensive level of care or service, and no less intensive services are appropriate.	**Any of the following criteria is 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 no longer meets admission criteria, or meets criteria

treatment modality as a component of a comprehensive treatment plan. 2) Biofeedback is a covered benefit with specific included diagnoses and the request for services is for a covered diagnosis listed in the most recent DSM; and can be reasonably expected to respond to this treatment modality as a component of a comprehensive treatment plan. 3) There are significant symptoms that interfere with the individual's ability to function in at least one life area. **Any** of the following criteria are sufficient for exclusion from this level of care: 1) Biofeedback is being requested for a physical health condition (request should be directed to medical plan). 2) The individual has conditions or impairments that would prevent beneficial utilization of Biofeedback. 3) Biofeedback is being requested for any behavioral health diagnosis except one specifically listed as a benefit or an Anxiety Disorder in the absence of specifically covered diagnoses listed in the most recent version of the DSM. 4) Biofeedback is not being used as an adjunctive treatment in a comprehensive treatment regimen. 5) Standard accepted outpatient treatments (including psychotherapy and medication management) are sufficient to safely and effectively treat the individual.	3) The frequency of sessions is occurring or scheduled to occur at a rate that is appropriate to the individual's current symptoms, and no less frequency of sessions would be sufficient to meet their needs. 4) Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. 5) All services and treatment are carefully structured to achieve optimum results in the most efficient manner possible, consistent with sound clinical practice. Expected benefit from the Biofeedback is documented. 6) Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident. or 7) Continued Biofeedback is expected to prevent the need for more intensive services or levels of care. 8) Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan. 9) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner. 10) There is documented active discharge planning from the beginning of treatment, which includes ensuring the	for a less or more intensive service or level of care. 3) The individual is competent and non-participatory in treatment, or the individual's non-participation is of such degree that treatment is rendered ineffective, or unsafe despite multiple, documented attempts to address non-participation issues. 4) Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision. 5) The individual is not making progress toward treatment goals, and there is no reasonable expectation of progress with this treatment approach. 6) It is reasonably predicted that continuing stabilization can occur with discontinuing Biofeedback with ongoing medication management and / or psychotherapy and community support.

	ability of the individual to continue the Biofeedback learned techniques independently after discharge.	

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NMNC 5.504.01 Outpatient Psychiatric Home Based Therapy (HBT)

Home-Based Therapy (HBT) is a short term service for members who:

- require additional support to successfully transition from an acute hospital setting to their home and community, or
- safely remain in their home or community but experience a temporary worsening, or new behavioral health need that may not be emergent, but without timely intervention could result in the need for a more intensive level of care than traditional outpatient treatment.

HBT brings the clinician to the member when there are delays or barriers to the member's timely access to a therapist. When used for transition from acute care, the HBT appointment is scheduled to occur within 48 hours of discharge from the acute mental health inpatient setting. The Beacon UR clinician may request that the HBT clinician visit the member in the hospital prior to discharge to explain HBT and ensure the member's willing participation in the service.

This level of care (LOC) requires a safe home environment that poses no safety risk to the HBT clinician. The HBT clinician does not replace the outpatient therapist, but reinforces the aftercare plan, assists to overcome any potential or identified barriers to care, helps identify resources for necessary community-based services, and bridges any delays or gaps in service. The HBT clinician may also work with the member's family to increase understanding of the member's condition and the importance of adherence.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
The following criteria must be met: 1) Member must have a DSM or corresponding ICD diagnosis 2) Member can be maintained adequately and safely in their home environment 3) Member is experiencing moderate to severe impairments in functioning due to psychiatric symptoms (i.e. self-care, occupational, school, family living, or social relations) 4) There is an expectation that the individual: 5) Has the capacity to engage and benefit from treatment 6) Agrees to participate in psychiatric home-based treatment 7) Has the potential to respond to therapeutic intervention 8) Has a combination of symptoms and psychosocial factors that may not be addressed adequately in a community	**All criteria 1-7 must be met:** 1) Member continues to meet admission criteria and another less intensive LOC is not appropriate 2) Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals 4) Member appears to be benefitting from the service. 5) Member is compliant with treatment plan and continues to be motivated for services. 6) Frequency and intensity of treatment contact occurs at a rate that is appropriate to the severity of current symptoms and a decrease would not	**Criteria 1, 2, or 3, are suitable; criteria 4, 5, and 6 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment. 3) Member and/or parent/caregiver do not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

setting? Member must also meet one of the following: 9) Require services beyond the scope of an office-based setting 10) Have a condition that keeps them from attending office-based treatment (i.e. medical condition, use of wheelchair or walker, requiring special transportation, etc.) 11) Leaving home setting would require considerable and taxing effort or is contraindicated due to member's condition. **Exclusions:** ***Any** of the following criteria are sufficient for exclusion from this level of care:* 1) The member requires structure and supervision beyond the scope of home-based services. 2) The member has a medical condition or impairments that would prevent beneficial utilization of services. 3) The primary problem is social, occupational, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration. 4) Treatment plan is designed to address goals other than the treatment of active symptoms of DSM or corresponding ICD diagnosis (e.g. self-actualization). 5) Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in	be sufficient to meet the member's needs. 7) Coordination of care and active discharge planning is ongoing, with the goal of transitioning member to a less intensive LOC.	

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resuming prior level of roles and responsibility.		

NMNC 6.601.2 Electro-Convulsive Therapy

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

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria 1-5 must be met: 1) DSM or corresponding ICD diagnosis of major depression, schizophrenia, schizoaffective mood disorder, or other disorder with features that include mania, psychosis, and/or catatonia; 2) Member has been medically cleared and there are no contraindications to ECT (i.e. Intracranial or cardiovascular, or pulmonary contraindications); 3) There is an immediate need for rapid, definitive response due to at least one of the following: 4) Significant risk of harm to self or others; 5) Catatonia 6) Intractable manic episode 7) Other treatments could potentially harm the member due to slower onset of action. 8) The benefits of ECT outweigh the risks of other treatments as evidenced by at least one of the following: a) Member has not responded to adequate medication trials; b) Member has had a history of positive response to ECT. 9) Maintenance ECT, as indicated by all of the following: a) Without maintenance ECT member is at risk relapse b) Adjunct therapy to pharmacotherapy	**All of the following criteria 1-8 must be met:** 1) The member continues to meet admission criteria; 2) An alternative treatment would not be more appropriate to address the members ongoing symptoms; 3) The member is in agreement to continue treatment of ECT; 4) Treatment is still necessary to reduce symptoms and improve functioning; 5) There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress; 6) The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects; 7) There is documented coordination with family and community supports as clinically appropriate;	**Any one or more of the following criteria**: 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member withdraws consent for treatment or refuses treatment and does not meet criteria for involuntary mandated treatment. 3) Member is not making progress toward goals, nor is there expectation of any progress. 4) Member's individual treatment plan and goals have been met. 5) Member's natural support (or other support) systems are in agreement with following through with member care, and the member is able to be in a less restrictive environment.

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c) Sessions tapered to lowest frequency that maintains baseline **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual can be safely maintained and effectively treated with a less intrusive therapy; or 2) Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific individual from this level of care. Such conditions include but are not limited to: a) unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease; b) aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure; c) increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions; d) recent cerebral infarction; e) pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia; and, f) anesthetic risk rated as American Society of Anesthesiologists level 4 or 5.	8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	

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NMNC 6.602.02 Repetitive Transcranial Magnetic Stimulation

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

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

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different medication classes; 7) Member must not meet any of the exclusionary criteria below; 8) rTMS is administered by a US Food and Drug Administration (FDA) cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters. 9) The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available). **The following criteria may apply:** History of response to TMS in a previous depressive episode as evidenced by a greater than 50% response in standard rating scale for depression (e.g., Geriatric Depression Scale (GDS), Personal Health Questionnaire Depression Scale (PHQ-9), Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR) and now has a relapse after remission and meets all other authorization criteria. **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. The safety and effectiveness of rTMS has not been established in the following member populations or clinical conditions through a controlled clinical trial, therefore the following are exclusion criteria. 3) <u>Members who have a suicide plan or have recently attempted suicide.</u> 4) Members who do not meet current DSM or corresponding ICD criteria for major depressive disorder.	7) There is documented coordination with family and community supports as appropriate; 8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	thoughts/behaviors or unusual behaviors.

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5) Members younger than 18 years of age or older than 70 years of age. 6) Members with history recent history of active of substance abuse, obsessive compulsive disorder or post-traumatic stress disorder. 7) Members with a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features. 8) Members with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS. 9) The presence of vagus nerve stimulator leads in the carotid sheath. 10) The presence of metal or conductive device in their head or body that is contraindicated with rTMS. For example, metals that are within 30cm of the magnetic coil and include, but are not limited to, cochlear implant, metal aneurysm coil or clips, bullet fragments, pacemakers, ocular implants, facial tattoos with metallic ink, implanted cardioverter defibrillator, metal plates, vagus nerve stimulator, deep brain stimulation devices and stents. 11) Members with Vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators. rTMS is not indicated for maintenance treatment. There is insufficient evidence to support the efficacy of maintenance therapy with rTMS. rTMS for maintenance treatment of major depressive disorder is experimental / investigational due to the lack of demonstrated efficacy in the published peer reviewed literature.		

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NMNC 6.603.02 Psychiatric Visiting Nurse (Home Health Services)		
Psychiatric Visiting Nursing/ Home Health Services is a short-term treatment delivered in the member's home or living environment to treat a DSM or corresponding ICD diagnosis with psychiatric medication management. This is most common after a member is discharged home from an inpatient psychiatric unit, and is considered high-risk for decompensation and readmission if their medication regime is not continued. Members approved for this level of care require ongoing intervention by nursing staff for psychiatric medication monitoring, usually due to a history of treatment non-compliance, or difficulties ambulating, which present a barrier for attending community medication management appointments. Psychiatric visiting nurses may also administer long-acting, injectable antipsychotic medications, obtain weekly blood work for a member, and provide other psychiatric nursing services for which they are licensed, until long term arrangements can be made. Psychiatric visiting nurse staff are generally employed by Home Health or Visiting Nurse agencies and would not function as an independent clinician or contractor.		
Admission Criteria	**Continued Stay Criteria**	**Discharge Criteria**
All of the following criteria must be met: 1) The member must have a DSM or corresponding ICD diagnosis; 2) Primary request for services is for assistance with psychiatric medication management; 3) Member can be adequately and safely maintained in the home; 4) The member is willing and motivated to receive psychiatric nursing/home care services. 5) Outpatient/community-based Medication management services are not adequate to stabilize the member or maintain current level of functioning due to at least one of the following: a) Member has complex co-morbid issues resulting in difficulty ambulating and attending community health treatment; b) Member requires long-term injectable medication and/or regular bloodwork to maintain stability on current medication regimen. 6) The member does not require a level of structure beyond the scope of psychiatric home care/visiting nursing services; 7) Without psychiatric visiting nurse/home services the member would be at high risk of requiring a higher level of care.	**All of the following criteria must be met:** 1) The member continues to meet admission criteria; 2) A less intensive level of care would not be adequate to administer care; 3) Treatment is still necessary to reduce symptoms and improve functioning; 4) Member's progress is monitored regularly, and the treatment plan modified, towards a set of clearly defined and measurable goals; 5) There is evidence of progress and the member appears to be benefitting from services; 6) The member is participating in the treatment plan; 7) Intensity and frequency of services is scheduled to occur/or is occurring at a rate appropriate for the member's current psychiatric symptoms; 8) Continuation of psychiatric nursing/home care services is necessary to prevent decompensation of symptoms and placement in a more restrictive treatment setting; 9) Coordination of care and active discharge planning is ongoing, with the goal of transitioning the member to a less intensive level of care.	**Any of the following: Criteria 1, 2, or 3; criteria 4 and 5 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member's individual treatment plan and goals have been met. 5) Member's support system is in agreement with the aftercare treatment plan.

Exclusions: **Any** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual requires a level of structure and supervision beyond the scope of Psychiatric Visiting Nurse services. 2) Member is receiving community based medication management services without contraindication/service interruption. 3) Intervention is requested for primary medical diagnosis.		

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NMNC 6.604.2 Applied Behavioral Analysis

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following must be met: 1) The member has behavioral symptoms consistent with a DSM or corresponding ICD diagnosis for Autism Spectrum Disorders or other diagnosis as required by state or federal law; 2) The diagnosis is determined by a qualified provider such as a developmental pediatrician, pediatric neurologist, psychiatrist or independently licensed and credentialed psychologist, or as permitted by state or federal law; 3) Member has specific challenging behavior(s) and/or level of functional deficits attributable to the autism spectrum disorder (e.g. self-injurious, stereotypic/repetitive behaviors, aggression toward others, elopement, severely disruptive behaviors) which result(s) in significant impairment in one or more of the following: a) personal care b) psychological function c) vocational function d) educational performance e) social function f) communication disorders 4) The member can be adequately and safely maintained in their home environment and does not require a more intensive level of care due to imminent risk to harm to self or others or severity of maladaptive behaviors 5) The member's challenging behavior(s) and/or level of functioning is expected to improve with IBI/ABA 6) The member is not currently receiving any other in home or office- based IBI/ABA services.	**All of the following must be met:** 1) Member continues to meet admission criteria; 2) There is no other level of care that would more appropriately address member's needs; 3) Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less restrictive level of care; 4) Treatment/intervention plan includes age appropriate, clearly defined behavioral interventions with measurable goals to target problematic behaviors. 5) Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives. 6) Medication assessment has been	**Any one of the following must be met:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care. 2) Member's individual treatment plan and goals have been met. 3) Parent / guardian / caregiver is capable of continuing the behavioral interventions. 4) Parent/guardian withdraws consent for treatment 5) Member is not making progress toward goals, nor is there any expectation of progress. 6) Member's support system is in agreement with the transition / discharge treatment plan.

Exclusions: ***Any** of the following criteria are sufficient for exclusion from this level of care:* 1) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. 3) The following services are not included within the ABA treatment process and will not be certified: a) Speech therapy (may be covered separately under health benefit) b) Occupational therapy (may be covered separately under health benefit) c) Physical Therapy d) Vocational rehabilitation (may be covered separately under health benefit) e) Supportive respite care f) Recreational therapy g) Orientation and mobility h) Respite care i) Equine therapy/Hippo therapy j) Dolphin therapy k) Other educational services	completed when appropriate and medication trials have been initiated or ruled out. 7) There is a documented active attempt at coordination of care with parent(s)/ guardian(s), relevant providers, etc., when appropriate. If coordination is not successful, the reasons are documented. 8) Coordination of care and discharge planning are ongoing with the goal of transitioning member to a less intensive behavioral intervention and a less intensive level of care.	

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NMNC 6. 605.01 Substance Use Laboratory Testing for Drug and Alcohol Use

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

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

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

Admission Criteria	Qualitative Testing	Quantitative Testing
1) The individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM (the most current version of the DSM substance use diagnosis. 2) The tests ordered are within the scope of license of the ordering practitioner. **Exclusions:** ***Any*** *of the following criteria is sufficient for exclusion:* 1) Quantitative testing or drug confirmation testing is excluded from coverage if performed for forensic or legal purposes. 2) Quantitative testing for negative screening results is excluded without written documentation of medical necessity and prior approval. 3) Quantitative testing requires a positive screening test and shall be performed only for the drug class represented by the positive screening. 4) Blood and urine screens ordered for the same drug panel on the same day will not be paid. 5) Quantitative or qualitative drug testing is excluded from coverage without current active treatment (evidenced by authorization, claims or provider attestation) for drug or alcohol treatment at the time of testing.	A screening immunoassay without confirmation or quantitative testing is typically sufficient for ongoing clinical monitoring. 1) Initial screening for substance use disorders, with rapid test immunoassay (5, 10 or 12 panel) and alcohol screening are recommended upon admission for the treatment of substance use disorder. 2) Post admission, screenings are expected and may be approved at a frequency not to exceed three (3) every thirty (30) days. 3) Testing at a frequency greater than three (3) times in thirty (30) days requires rationale documented in medical record and must meet medical necessity. 4) On site Clinical Laboratory Improvement Act (CLIA)-waived testing is preferred as results can rapidly be integrated into treatment decisions and clinical assessment.	Most positive screening results are confirmed by the patient's self-disclosed admission of substance use. All orders for quantitative testing of drugs of abuse require a positive screening test and shall be performed only for the drug class represented by the positive screening. 1) Documentation of medical necessity for quantitative testing is required in the medical record. 2) Quantitative testing exceeding three (3) procedure codes or drug classes every thirty (30) days requires rationale documented in medical record and must meet medical necessity.

Assertive Community Treatment (ACT)

The purpose of Assertive Community Treatment (ACT) is to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional service delivery approaches. ACT provides an integrated set of other evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of team meetings.

Initial Authorization Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 - 5 must be met; **Criteria 6 & 7 may also be met:** 1. Severe and persistent mental illness (including, but, not limited to diagnoses of schizophrenia, schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community. 2. Recipients with serious functional impairments should demonstrate at least one of the following conditions: a. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives. b. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role. c. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).	1. Initial authorization criteria continue to be met. 2. A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals. Service plan is reviewed for progress and updated every 6 months as necessary 3. Continued coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc. 4. Active discharge planning is ongoing, with goal of transitioning the member to a	ACT recipients meeting any of the following criteria may be discharged: 1. Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service. 2. Individuals who move outside the geographic area of the ACT team's responsibility, subsequent to the transfer of care to another ACT team or other appropriate provider and continued services until the member is engaged in care.

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3. Recipients with continuous high service needs should demonstrate one or more of the following conditions: a. Inability to participate or succeed in traditional, office-based services or case management. b. High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year). c. High use of psychiatric emergency or crisis services. d. Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues). e. Co-existing substance abuse disorder (duration greater than 6 months). f. Current high risk or recent history of criminal justice involvement. g. Court ordered pursuant to participate in Assisted Outpatient Treatment. h. Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless. i. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. j. Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services. 4. Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision.	less intensive LOC, when appropriate.	3. Individuals who need a medical nursing home placement, as determined by a physician. 4. Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail. 5. Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement. 6. Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons", including, but, not limited to, conferring with Health Homes and

5. Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions. 6. Member is stepping down from a higher level of care (LOC) and requires more intensive services than routine outpatient behavioral health treatment or other community based supports; and/or has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher LOC. 7. For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate. 8. Priority is given to individuals with SMI, individuals with continuous high service needs that are not being met in more traditional service settings, and individuals with ACT in their AOT order 9. Exclusion criteria: Individuals with a primary diagnosis of a substance abuse disorder or mental retardation and members with a sole diagnosis of a personality disorder are not appropriate for ACT 10. The member is not enrolled in HCBS services other than crisis residential services.		MMCO/HARPs, to which Member may be assigned.

Wraparound with Intensive Services (WISe)

Wraparound with Intensive Services (WISe) is designed to provide comprehensive behavioral health services and supports to eligible individuals, up to 21 years of age, with complex behavioral health needs and their families. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Have a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; 4. For whom intensive mental health services provided in the home and community based would address or ameliorate a mental illness or condition.	1. All of the following criteria must be met: 2. Member continues to meet admission criteria and another LOC is not appropriate. 3. Progress in relation to specific behavior, symptoms, or impairments is evident and documented, but goals have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident. 4. Member is actively participating in care to the extent possible. M 5. Parent/guardian/caregiver and/or natural supports are actively involved, where appropriate.	Any one of the following criteria is suitable: 1. Member no longer meets admission criteria, or meets criteria for another LOC, either more or less intensive. 2. Treatment plan goals and objectives have been substantially met and continued services are not necessary to prevent the worsening of member's behavioral health condition. 3. Member and/or parent/guardian/caregiver are not engaged in treatment to such a degree that treatment at this LOC becomes ineffective or unsafe, despite multiple documented attempts to address engagement issues. 4. Member, parent or guardian withdraws consent for treatment. 5. Member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this LOC, nor is it required to maintain the current level of functioning. 6. Youth is placed in a 24 hour treatment setting and is not ready for discharge to a family home environment or a community setting.

Respite Services

Respite is a service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual in service by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the individual in service or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. Member has a DSM or corresponding ICD psychiatric, medical, or developmental diagnosis made by a licensed health care professional with competence in child psychology child psychiatry, or child development; causing significant impairment of functioning and negatively impacting parent/guardian/caregiver and home environment. 2. Member does not meet LOC for a more intensive service. 3. Member lives with parent/guardian/caregiver in the community; and the parent/guardian/caregiver are capable and willing to participate, accept the responsibilities of, and cooperate with the program requirements.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria. 2. Caregiver continues to need assistance to successfully care for the member in the home/community.	**Any one of the following criteria is suitable:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC. 2. The member's home environment presents safety risks to the respite worker. 3. Parent/guardian/caregiver no longer needs this level of clinical support and is actively utilizing other formal and/or informal support networks. 4. The member, family, or guardian is not successfully following program rules or regulations and is no longer capable or willing to participate to the extent required and agreed upon. 5. Parent/guardian/caregiver withdraws consent for the service. 6. The member is admitted to an institutional care setting for long-term care.

4. Respite can be provided in the home or community without compromising the member's or respite worker's health and safety. 5. Caregiver requires assistance to successfully care for the member in the home/community.		

Mental Health Clubhouse

Mental Health Clubhouse provides an individual in service directed program where they receive multiple services. These services may be in the form of support groups, related meetings, individual in service training, peer support, etc. Individual in service may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use International Center for Clubhouse Development (ICCD) standards as guidelines.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in clubhouse treatment. 5. An individual must have the desire and willingness to receive rehabilitation and recovery services as part of their individual recovery plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a clubhouse level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without clubhouse services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets clubhouse level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional clubhouse services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.