

**Behavioral Health Partnership –
Adult Psychiatric
Level of Care Guidelines**

Final

11/10/05

Guidelines for Making Level of Care Decisions

These Level of Care guidelines are designed to assist care managers and providers in assessing a patient's clinical presentation and determining the appropriate level of care. This document should be used as a guideline for facilitating access to the treatment setting and interventions based on a patient's severity of illness and intensity of service need. In general, patients should be placed in the least restrictive level of care that is warranted by the severity of presenting symptoms, degree of functional impairment and environmental circumstances. The level of treatment intervention should match the presentation that necessitated the intervention. The ASO will allow for multiple levels of care to be authorized concurrently for the purpose of treatment continuity and flexibility in service planning. In all cases, the ASO will give due consideration to patient choice and the provider's expertise and will engage in a highly collaborative care decision-making process with providers.

These guidelines are governed by the definitions of "medical necessity", "medical appropriateness" and "EPSDT" (for members under twenty-one) included at the end of this document. Costs may be factored into decision-making only when two alternative treatments are equally effective.

A. Application of the Criteria

The application of the severity of illness criteria may be influenced by a variety of factors related to the patient's psychiatric condition and living environment. Aspects of a patient's condition that might warrant consideration in making level of care decisions include the following:

- Co-morbid psychiatric conditions
- Co-morbid substance use conditions
- Co-morbid developmental disabilities
- Co-morbid biomedical conditions
- Persistence of symptoms
- Relapse potential
- Prevalence of risk behaviors and victimization issues

Environmental factors that may influence level of care decisions include:

- Residence (e.g., home, shelter,)
- Family functioning
- Major life events
- Abuse/neglect
- Treatment motivation
- Vocational or Educational functioning

Although admission and continued care decisions should not be made solely on the basis of environmentally based risk, these factors need to be considered in treatment planning. Environmentally based factors may provide the impetus for continuing

services or for facilitating access to a higher or lower level of care. Strengths and supportive factors should be considered in all care decision making.

When clinical presentation supports more than one level of care, the intensity of service need, prior treatment history and the presence of protective factors are used to determine the most appropriate level of care.

B. Mitigating Factors

Although efforts should always be made to review a patient's course of treatment and level of care determination based on clinical and environmental factors listed above, there are particular events that might require a decision that falls out of the parameters listed above. Special consideration may be made when:

- The level of care that the patient needs and is eligible for is currently not available and the patient's safety and well being requires placement in an alternative level of care, irrespective of clinical need

C. Medicaid Definitions

1. Medical Necessity - Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.
2. Medical Appropriateness - Health care that is provided in a timely manner and that meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.
3. EPSDT – Connecticut Medicaid recipients under the age of twenty one (21) are entitled to the benefits of the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program, which includes an age-appropriate behavioral health and developmental assessment and any medically necessary follow-up treatment.

The HUSKY A MCOs are responsible for ensuring the provision of a behavioral health assessment for patients *under the age of twenty one (21)*. A patient under 21 may be referred to either the MCO or the ASO for an inter-periodic screen by a professional who comes in contact with a patient outside of the formal health care system. The ASO is responsible for ensuring the provision of an inter-periodic assessment of the patient's behavioral health when the patient is referred either directly to a behavioral health provider in the BHP network or to an ASO care manager.

The ASO's care managers or other ASO staff must authorize all medically necessary behavioral health services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic screening including medically necessary health care services

that are not otherwise covered under the Connecticut Medicaid program. Care managers or other ASO staff are also required to facilitate access to such services when contacted by the recipient or the recipient's designated representative.

A. ACUTE INPATIENT PSYCHIATRIC HOSPITALIZATION - ADULT

Definition

Inpatient treatment services in a licensed general, psychiatric hospital or a state operated psychiatric hospital offering a full range of diagnostic, educational, and therapeutic services with capability for emergency implementation of life-saving medical and psychiatric interventions. Services are provided in a physically secured setting. Patient admission into this level of care is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is *generally* used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. The first authorization is for up to 3 days. Subsequent authorizations are based on the individual needs of the patient and with consideration of the physician's recommendations.

All inpatient admissions pursuant to an order of the court within the context of the jail diversion program or the Psychiatric Security Review Board (PSRB) shall be deemed medically necessary and so authorized.

Level of Care Guidelines:

A.1.0 Admission Criteria

A.1.1 Symptoms and functional impairment include all of the following:

A.1.1.1 Diagnosable DSM Axis I or Axis II disorder,

A.1.1.2 Symptoms and impairment must be *primarily* the result of a psychiatric disorder, excluding V-codes,

A.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, or substance use and

A.1.1.4 GAF <30

A.1.2 Presentation consistent with at least one of the following **Symptom Categories:**

A.1.2.1 Current risk of suicide/self-injury: Imminent risk of suicide or self-injury, with an inability to guarantee safety in a less restrictive environment as manifested by:

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- A.1.2.1.1 Attempt: Recent and serious suicide attempt indicated by degree of lethal intent, impulsiveness of actions and/or substance use. Inability to reliably contract for safety; or
- A.1.2.1.2 Intent/Plan: Current suicidal ideation with plan, imminent intent to act and available means that is severe and dangerous with minimal expressed ambivalence or significant barriers to doing so; or
- A.1.2.1.3 Self-mutilation: Recent self-mutilation that is severe and dangerous, e.g., deep cuts requiring sutures, 2nd to 3rd degree burns, swallowing objects; or
- A.1.2.1.4 Hallucinations and/or Delusions: Recent command/threatening hallucinations or delusions that threaten to override usual impulse control and likely to result in harm to self or others; or
- A.1.2.2 Current risk of homicide/danger to others: Imminent risk of homicide or harm to others with inability to guarantee safety in a less restrictive environment as manifested by:
 - A.1.2.2.1 Attempt: Recent and serious homicide attempt indicated by degree of lethal intent, impulsivity and/or substance use, severe and dangerous, or inability to reliably contract for safety or a history of serious past attempts that are not of a chronic, impulsive, or consistent nature; or
 - A.1.2.2.2 Intent/Plan: Current homicidal ideation with plan, imminent intent to act and available means that is severe and dangerous with minimal expressed ambivalence or significant barriers to doing so; or
 - A.1.2.2.3 Severe assault: Recent physically assaultive behavior with a high potential for recurrence and high potential for serious injury to self or others; or
 - A.1.2.2.4 Hallucinations and/or Delusions: Recent command/threatening hallucinations likely to result in harm to self or others; or
 - A.1.2.2.5 Agitation/Aggression: Sustained agitated and uncontrolled behavior including acts of violence against property or persons with high risk of recurrence.

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- A.1.2.3 Gravely Disabled: Acute and serious deterioration from baseline in mental status and level of functioning resulting in high risk of harm to self or others. Severe impairment of activities of daily living skills and not secondary to abuse or neglect as evidenced by one or more of the following:
- A.1.2.3.1 Malnutrition of life-threatening severity and/or highly compromised nutrition or eating patterns (e.g. eating only food packaged in cellophane, eating only peas counted out one by one) which may be related to paranoid, delusional, or severe eating-disordered beliefs or rituals; or
 - A.1.2.3.2 Immobility with potential to compromise physical status; or
 - A.1.2.3.3 Unable to communicate basic needs
 - A.1.2.3.4 Catatonia; or
 - A.1.2.3.5 Severe psychomotor agitation (inability to sit still not related to ADHD or medication side effects; several nights without sleeping due to emotional agitation and/or delusions or paranoia; emotional lability with persistent pacing, with or without property damage, unresponsive to support or limits from others); or
 - A.1.2.3.6 Response to command/threatening hallucinations which could result in harm to self/others; or
 - A.1.2.3.7 Response to delusions, excessive preoccupations, inability to sort out fantasy from reality, or grossly impaired judgment which interfere with functioning and places the individual or others at risk (e.g., paranoid ideas that inspire retaliation; delusions of invincibility that lead patient to place self in harm's way, or
 - A.1.2.3.8 Disorientation to person, place and time; or
 - A.1.2.3.9 Delirium; or
 - A.1.2.3.10 Dissociative events, which could result in harm to self/others.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- A.1.2.4 Acute Medical Risk: Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom(s) manifested by:
 - A.1.2.4.1 Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious medical illness requiring inpatient medical services (e.g., endocrine disorders such as diabetes and thyroid disease; cardiac conditions; etc.); or
 - A.1.2.4.2 A need for acute psychiatric interventions (e.g., drug, ECT, restraint) that have a high probability of resulting in serious and acute deterioration of physical and/or medical health; or
 - A.1.2.4.3 Not eating and/or excessive exercise to the point that further weight loss is medically threatening.
- A.1.2.5 Medication Adjustment: Patient has met any of the above symptoms within the past 12 months and requires a medication taper and re-evaluation in an inpatient hospital setting. Previous attempts to taper medication have resulted in behavioral escalations that meet admission criteria for inpatient hospitalization, or result in significant medical risk.

And meets at least one of the following criteria:

- A.1.3 Intensity of Service Need
 - A.1.3.1 Individual requires inpatient psychiatric care with 24-hour medical management. The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of care as evidenced by:
 - A.1.3.1.1 Psychiatric treatment (e.g., medication, ECT) presents a significant risk of serious medical compromise (e.g., ECT for a patient with a cardiac condition, restraint or seclusion of a patient with a cardiac condition, initiation of or change in neuroleptic medication for a patient with history of neuroleptic malignancy syndrome, or administration of depakote to a patient with a history of neutropenia); or
 - A.1.3.1.2 Patient requires or is likely to have diagnostic or evaluative procedures readily available in a hospital

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setting (e.g., MRI, 24-hour EEG, neurological examination, or specialized lab work, etc.); or

- A.1.3.1.3 Intrusive route of medication administration requires medical management (e.g., intramuscular administration of PRN medication or administration by means of an NG tube); or.
- A.1.3.1.4 Patient requires 1:1 supervision or frequent checks for safety (e.g., every 15 minutes or less); or
- A.1.3.1.5 Efforts to manage medical risk symptom or behavior (see III.A.1.b.(4)) in a lower level of care are ineffective or result in an acute escalation of behavior with risk of harm to self or others; or
- A.1.3.1.6 Patient requires close medical monitoring or skilled care to adjust dosage of psychotropic medications and such medical monitoring and dosage adjustment could not safely be conducted in a lower level of care; or
- A.1.3.1.7 Patient demonstrates grave disability and has not responded to intervention or an alternative level of care or supports are not available.

A.2.0 Continued Care Criteria

- A.2.1 Patient has met admission criteria within the past 48 hours or has been prevented from engaging in qualifying behavior due to use of 1:1 supervision, frequent checks (q5), physical/mechanical restraint, or locked seclusion; or
- A.2.2 Evidence of active treatment and care management as evidenced by:
 - A.2.2.1 Patient participation in treatment consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency, and intensity of services are consistent with the treatment plan, and
 - A.2.2.2 A treatment plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored daily, and
 - A.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

meetings with aftercare providers, identifying and referring for aftercare, scheduling initial aftercare appointments).

A.2.3 If the patient does not meet criterion A.2.1, continued stay may still be authorized under any of the following exceptional circumstances:

A.2.3.1 Patient has clear behaviorally defined treatment objectives that can reasonably be achieved within this level of care and are determined necessary in order for the discharge plan to be successful, and there is no other suitable environment in which the objectives can be safely accomplished; or

A.2.3.2 Patient can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to the community rather than to another institutional setting; or

Note 1: Intensive Care Management

The patient should be considered for referral to Intensive Care Management if there is significant risk of readmission or additional development of the aftercare plan is required post discharge. The ICM should coordinate with the Local Mental Health Authority or the patient's primary mental health provider in the development of an appropriate aftercare plan for patients that meet the DMHAS target population definition.

Note 2: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

B. INTERMEDIATE CARE

Definition

Intermediate care refers to ambulatory psychiatric treatment programs that offer intensive, coordinated and structured clinical and assessment services within a stable therapeutic milieu. These programs encompass partial hospital (PHP), and intensive outpatient (IOP) levels of care. All programs require psychiatric evaluation, treatment planning and oversight and typically serve as a step down to, or diversion from, inpatient levels of psychiatric care. Multiple treatment modalities (i.e., individual therapy, group therapy, family therapy, medication management, rehabilitative therapies) are integrated within a single treatment plan that focuses on patient specific goals and objectives. Services vary according to intensity of service (day/hours offered weekly) and length of stay.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. Time frame for initial authorization is individualized according to intensity of client need and type of program for which admission is sought. Generally, PHP and IOP provide intensive service over a brief period of time to stabilize a client's functioning. Some IOP level services are specialized in clinical focus or treatment model and are operated as intensive service components of outpatient clinics.

Use of Guidelines

The following guidelines are to be used when determining access to these two levels of Intermediate Care. Differences in admission, intensity of service need, and continued care for each of these services are addressed in the service grid to be used conjointly with these guidelines.

Level of Care Guidelines:

B.1.0 Admission Criteria

- B.1.1 Symptoms and functional impairment include all of the following:
 - B.1.1.1 Diagnosable DSM IV Axis I or Axis II disorder,
 - B.1.1.2 Symptoms and impairment must be the result of a psychiatric disorder excluding V-codes,
 - B.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, and

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

B.1.1.4 Acute onset or exacerbation of an illness or persistent presentation (e.g., over 6 month period) of at least one of the following **Symptom Categories**:

B.1.1.4.1 Suicidal gestures or attempts, or suicidal ideation or threats that are serious enough to lead to suicidal attempts; or

B.1.1.4.2 Self-mutilation that is *moderate to severe* and dangerous; or

B.1.1.4.3 Deliberate attempts to inflict serious injury on another person; or

B.1.1.4.4 Dangerous or destructive behavior as evidenced by episodes of impulsive or physically or sexually aggressive behavior that present a moderate risk; or

B.1.1.4.5 Psychotic symptoms or behavior that poses a moderate risk to the safety of the patient or others; or

B.1.1.4.6 Marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression.

And meets at least one of the following criteria:

B.1.2 Intensity of Service Need

B.1.2.1 The patient requires an organized, structured program several days each week. The intensity of service and the length of stay vary according to patient needs and the corresponding program. The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:

B.1.2.1.1 One or more recent efforts to provide or enhance outpatient treatment have been unsuccessful; or

B.1.2.1.2 Recent attempts to engage the patient in outpatient therapy have been unsuccessful or the patient has been noncompliant with treatment; or

B.1.2.1.3 Patient is acutely symptomatic and needs to be stepped down or diverted from inpatient level of care. Patient remains moderately to severely

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

symptomatic and there is high likelihood that patient's condition would deteriorate if treated in a lower level of care.

Program Specific Requirements:

PHP: The patient demonstrates severe and disabling symptomatology that severely impairs the patient's capacity to function adequately in multiple areas of life on a day-to-day basis. It is highly likely that the patient will require an inpatient level of care or will quickly deteriorate to a level of functioning that would require an inpatient admission without the intensive daily services of the PHP level of care. The patient requires at least 4 hours/day of structured programming three to five days a week for a brief period of time. May need continued diagnostic work and medication evaluation.

IOP: Patient demonstrates moderate level of symptomatology that has a moderate impact on the patient's capacity to function adequately in multiple areas of life on a day-to-day basis. The patient is at substantial risk for further decompensation, deterioration or self-harm and inpatient hospitalization without IOP services. Patient requires 2-4 hours/day of structured programming for 2-5 days per week.. *Some specialized IOP programs may require longer lengths of stay.* Requires little or no additional diagnostic work but may require medication management. Has been unsuccessful in outpatient treatment or is stepping down from PHP or inpatient level of care and meets criteria for IOP level of care..

B.2.0 Continued Care Criteria

B.2.1 Patient has met admission criteria within the past three (3) days for PHP, and five (5) days for IOP as evidenced by:

B.2.1.1 The patient's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or

B.2.1.2 The patient has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals, and

B.2.2 Evidence of active treatment and care management as evidenced by:

B.2.2.1 A treatment plan has been established with evaluation and treatment objectives appropriate for this level of care.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and

B.2.2.2 Patient's participation in treatment is consistent with treatment plan or active efforts to engage the patient are in process. Type, frequency and intensity of services are consistent with treatment plan, and

B.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).

B.2.3 If patient does not meet above criteria, continued stay may still be authorized under any of the following circumstances:

B.2.3.1 Patient has clear behaviorally defined treatment objectives that can reasonably be achieved and are determined necessary in order for the discharge plan to be successful, and there is not a suitable lower level of care in which the objectives can be safely accomplished; or

B.2.3.2 Patient can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to a lower level of care rather than to a more restrictive setting; or

B.2.3.3 Patient is gradually decreasing time at program towards goal of discharge and is transitioning to a lower level of care while being monitored to determine if patient maintains gains made in program.

Note: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

ADULT Guidelines

Intermediate Levels of Care – Partial Hospital, Intensive Outpatient

| Aspects of Care | Partial Hospitalization | Intensive Outpatient |
|---|--|---|
| Hours Per Day | 4 –6 Hours Per Day | 2-4 Hours Per Day |
| Days Per Week | 3-5 Days per week | 2-5 Days per week |
| GAF | <50 | <55 |
| Medical Oversight | Participants are under the care of a physician who directs treatment. Client requires frequent medical monitoring, adjustments and observation of side effects on daily basis by medically trained staff. Typically involves daily rounds. | Participants are under the care of a physician who directs treatment. Client may require medical monitoring, adjustments and observation of side effects by medically trained staff. |
| Community Based Rehabilitative Therapies | Rehabilitative therapies (i.e., activities that restore social skills, activities of daily living) may be incorporated into the milieu. Services are provided on-site, the goals are short-term. | Rehabilitative therapies (i.e., activities that restore social skills, activities of daily living) may be incorporated into the milieu. Services are provided on-site, the goals are short-term. |
| Therapy | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family involvement is desirable unless contraindicated. | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family involvement is desirable unless contraindicated. |
| Target Length of Stay | 2-4 weeks | 2-6 weeks |
| Clinical Intensity | Patient demonstrates severe level of symptomatology requiring 4-6 hours/day of structured programming three to five days a week for brief period of time. May need continued diagnostic work and medication evaluation. May have been unsuccessful in IOP or other day program or may have recently been released from inpatient level of care or may have recently been unsuccessful in outpatient level of care. | Patient demonstrates moderate level of symptomatology requiring 2-4 hours/day of structured programming for 2-5 days per week. Requires little or no diagnostic work but may require medication management. Has been unsuccessful in outpatient or other community-based programs or is stepping down from PHP or inpatient level of care and meets admission criteria for IOP level of care. |

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

C. OUTPATIENT THERAPY - ADULT

Definition

Outpatient therapy services are ambulatory clinical services provided by a general hospital, private freestanding psychiatric hospital, psychiatric outpatient clinic, state-operated facility, or by a licensed mental health practitioner practicing independently or in a private practice group. This service involves the evaluation, diagnosis, and treatment of individuals, families or groups as well as medication management. Services are typically scheduled in advance, but may occur urgently without a scheduled appointment. Services are provided at a frequency designed to address immediate clinical need as directed by an individual treatment plan. Outpatient services are designed to promote, restore, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued as the patient is able to function more effectively.

A patient can receive services from more than one provider (e.g., clinic, independent practitioner) at any given time offering individual, family, group or medication management services, provided the services are not duplicative. Based on clinical necessity and with review by a care manager, a client may be authorized to receive an outpatient service while simultaneously participating in a higher level of care.

Authorization Process and Time Frame for Service:

This level of care does *not* require prior authorization initially. However, registration *is* required which results in an initial authorization of twenty-six (26) sessions covering a twelve-month period of time. Visits in excess of 26 or those beyond the initial twelve-month period would require prior authorization.

Level of Care Guidelines

C.1.0 Admission Criteria:

C.1.1 Symptoms and functional impairment include all of the following:

C.1.1.1 Diagnosable DSM-IV Axis I or Axis II disorder,

C.1.1.2 Symptoms and impairment must be the result of a psychiatric or Substance abuse disorder,

C.1.1.3 Functional impairment not solely a result of Mental Retardation, and

C.1.1.4 GAF <70

C.1.2 Intensity of Service Need

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- C.1.2.1 Patient is experiencing behavioral and/or emotional problems as described in the DSM-IV that can be assessed or safely addressed in an outpatient setting using one or more of the treatment modalities defined above.

C.2.0 Continued Care Criteria

- C.2.1 The patient has met criteria for outpatient care and there is evidence of active treatment and care management as evidenced by:
 - C.2.1.1 Patient participation in treatment consistent with treatment plan, or active efforts to engage the patient is in process. Type, frequency and intensity of services are consistent with treatment plan, and
 - C.2.1.2 A treatment plan with goals and treatment objectives appropriate for this level of care has been established and treatment objectives are related to readiness for discharge, progress towards objectives is being monitored and the patient is making measurable progress but identified objectives have not yet been met.
- C.2.2 If the patient does not meet criteria listed above, additional outpatient services may be authorized if either of the following are true:
 - C.2.2.1 There is evidence that the patient will not be able to maintain functioning without sustained or significant deterioration if treatment is discontinued, or
 - C.2.2.2 There is an anticipated stressor within the patient's immediate social or family environment that, based on clinical history could reliably predict behavioral and emotional regression (i.e., impending birth of child, divorce, scheduled medical procedure, change in home environment, etc.).
- C.2.3 The patient does **not** meet continued care criteria if:
 - C.2.3.1 The patient has met treatment goals or the patient has demonstrated minimal or no progress toward treatment goals for a three-month period and appropriate modifications of treatment plan have been made and implemented with no significant progress, suggesting the patient is not benefiting from outpatient therapy services at this time.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

Note: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

D. PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING – ADULT

Definition:

Psychological Testing involves the administration and interpretation of standardized tests used to assess an individual's psychological or cognitive functioning. It assists in gaining an understanding of an individual's diagnostic presentation and informs the appropriate course of treatment. Psychological evaluation using various measures may be conducted to clarify a psychiatric diagnosis in situations in which: 1) there is current symptomatic behavior that disrupts functioning and, 2) there is a lack of diagnostic clarity that can not be resolved by standard interview techniques and, 3) this lack of diagnostic clarity is preventing the development or revision of an appropriate treatment plan. Results would be used to determine the best possible treatment approaches, clarify specific client needs, identify client strengths, or distinguish necessary interventions for best clinical utility. Common types of tests are: projective and/or objective personality assessments, intelligence assessments, adaptive living scales, and neuropsychological assessments.

All testing must be done in accordance with the American Psychological Association's Standards for Educational and Psychological Testing. As such, testing must be administered and interpreted by a licensed psychologist and any measure used must have documented standardization, reliability, and evidence that it is appropriate for its intended use and that it enhances diagnostic accuracy. Test results will lead to child specific clinical recommendations that will be shared with caregivers with appropriate release of information as indicated.

Authorization Process and Time Frame for Service:

This service requires prior authorization through the submission of a Request for Psychological Testing form. Requests for psychological testing must target specific diagnostic questions and address the reasons why standard interview techniques or therapies cannot resolve those questions. All children/adolescents referred for psychological or neuropsychological testing and their caregivers may require a preliminary diagnostic interview by the Psychologist scheduled to perform the testing. This interview will allow the Psychologist to identify the specific test instruments needed to address the referral issues.

Once the preliminary diagnostic interview is completed, the psychologist will complete the Request for Psychological Testing Form. Each test and its clinical rationale must be listed. In addition, the time allocation for each test instrument to be used must be estimated based on information from test manufacturers, or, in the absence of such, based on time allotment approved by the Clinical Management Committee. It is expected that certain tests will be scored by computer and additional time for hand scoring will not be authorized. Authorization for this service will be granted not more frequently that once every 12 months unless there is compelling evidence of marked change and 1) there is

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

substantial clinical reason to suspect organic or trauma related deterioration or 2) previous test results are deemed invalid due to inappropriate administration or 3) client performance was impaired by issues that were unknown to the psychologist at the time of test administration (i.e., child was becoming physically ill, child had recently been traumatized)

Level of Care Guidelines

D.1.0 Admission Criteria

D.1.1 Severity of Symptoms and Functional Impairment

D.1.1.1 The individual has or is believed to have a diagnosable DSM IV Axis I or Axis II disorder, excluding V-codes (neuropsychological testing should be performed for the diagnosis and treatment of an organic disorder,) and

D.1.1.2 Individual evidences significant functional impairment secondary to the above disorder, and

D.1.2 Intensity of Service Need

D.1.2.1 One or more of the following criteria must be met:

D.1.2.1.1 Traditional clinical assessment has not proven effective in identifying the underlying cause for the client's behavioral distress and testing is needed to determine diagnosis and the most appropriate course of treatment; or

D.1.2.1.2 The child/adolescent has not responded to traditional treatment with out a clear explanation of treatment failure and testing is necessary to address issues related to differential diagnosis, and

D.1.2.1.3 The testing will have a timely effect on the revised treatment planning process.

D.1.3 Additional Variables to be Considered:

D.1.3.1 Valid testing was not administered within the last year or there is sufficient justification for repeat/additional testing, and

D.1.3.2 Testing is not routine but medically necessary, and

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- D.1.3.3 Primary purpose of testing is not for educational, vocational, or legal purposes, and
- D.1.3.4 The child/adolescent is not under the influence of alcohol or other substances, undergoing detoxification, or experiencing residual or temporary effects of substance use that are likely to compromise the validity of testing, and
- D.1.3.5 Symptoms of acute psychosis will not interfere with proposed testing validity, and
- D.1.3.6 The time requested for test/test battery does not fall outside of the manufacturer's or the Clinical Management Committee's recommended time frames.

D.2.0 Continued Care Criteria – Not applicable

Note: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.