Medical Necessity Criteria

Acute INPATIENT

1. Member presents as a significant danger to self as evidenced by person is at imminent risk to self or others or unable to meet their basic needs due to a major mental illness , or member is at high risk for self destructive acts secondary to severe psychiatric symptoms (i.e. command hallucinations or persecutory delusions); **OR**
2. Member is at significant risk of committing violent, aggressive or impulsive acts that can best be explained as resulting from a severe emotional state or exacerbation of an existing psychiatric condition; **OR**
3. Member has acute onset of psychosis, severe thought disorganization or deterioration of a chronic psychotic condition so that the member is unmanageable and unable to cooperate in treatment in a less restrictive, less intensive setting; **OR**
4. Member needs psychiatric medication adjustment that cannot be managed in the community including monitored administration of medication; **OR**
5. Member presents severe functional impairment resulting from an acute psychiatric condition such that the member is unable to provide for basic self-care without 24-hour supervision; **OR**
6. Member meets the crisis respite admission criteria; AND

   No respite bed is currently available; **OR**

   The member is considered an elopement risk; **OR**

   It is considered likely that the member will require restraint or seclusion; **OR**

   The member's condition is such that proposed treatments require 24 hour nursing observation (i.e. tube feedings, ECT, IV therapy) which are not appropriate outside of a hospital setting and are not primarily for a medical condition.

SUB-ACUTE

1. The member exhibits risk factors for self harm (e.g., frequent suicidal ideation, a recent gesture) such that safety cannot be reasonably assured outside of a structured overnight setting. The risk of self harm is secondary to psychiatric symptoms such as depression, command hallucinations or persecutory delusions; **OR**
2. The member is experiencing an increase in psychotic symptoms and the member cannot be managed in a less restrictive, structured environment; **OR**
3. The member is at risk of committing aggressive or impulsive acts resulting from emotional distress related to a psychiatric condition; **OR**

The member presents sufficient functional impairment resulting from a psychiatric condition such that the member is unable to provide for basic self-care without 24-hour supervision.

Member needs Psychiatric medication adjustment that cannot be managed in the community including monitored administration of medication.

AND

It is anticipated that the member will benefit from the level of care available in the Sub-Acute facility. The member has the potential of becoming an imminent risk to self or others as evidenced by recent or ongoing unpredictable dangerous behaviors.

Psychiatric Residential

1. Primary DSM Axis I mental health diagnosis above the funded line on the Oregon Health Plan Prioritized List of Health Services. This diagnosis must be the focus of the treatment requested.
2. Behaviors considered responsive to treatment in a residential setting:
    - Active psychosis
    - Risk of harm (homicidal or suicidal ideation) when insufficient mental health services and supports exist in the community
    - Need for active psychiatric treatment under the direction of a child psychiatrist 24 hours/7 days a week.
3. Primary diagnoses not paired with residential treatment on the Oregon Health Plan Prioritized List of Health Services and therefore not covered for treatment in a residential setting
    - Attention Deficit Hyperactivity Disorder
    - Adjustment Disorder
    - Substance abuse
    - Developmental disability
4. Behaviors not considered responsive to or best practice to treat in a psychiatric residential setting:
    - Primary behavior associated with diagnoses of Reactive Attachment Disorder, Oppositional Defiant Disorder or Conduct Disorder with symptoms not directly related to a psychotic disorder.
    - Primary behavior includes:
    - Bullying others
    - Physical aggression
    - Sexual offending behavior
    - Property destruction
    - Fire setting
    - Truancy
    - Running away
    - Pattern of defiant behavior
    - Indiscriminate sociability (excessive familiarity with strangers)
5. Level of Need Determination Screening process, including administration of the Child and Adolescent Service Intensity Instrument, results in a determination that psychiatric residential treatment is appropriate.
6. Documentation of attempts at lower levels of treatment and community intervention OR the child’s mental health treatment needs cannot be adequately met in a less restrictive setting.
7. Child and Family Team agree on this intervention as being most appropriate and it is included in the service coordination plan.

8. Admission is not solely for placement or for the convenience of the family, the provider or other child-serving agencies.
9. Prior to admission there is an identified discharge plan, including a community plan
10. Psychiatric assessment has occurred within 60 days of potential placement date

Continued stay criteria:

- Continued risk of harm to self or others if returned to the community
- Client continues to require active psychiatric treatment under the direction of a child psychiatrist 24hours/7 days a week
- Client is benefitting from current level of treatment
- Mental health needs cannot be met in less restrictive environment

Psychiatric Day Treatment Referral, Determination and Transition:

1. Ambulatory resources available in the community do not meet the child's mental health treatment needs as determined by the established Child and Family/Wraparound Team. The team has identified a need best met in a day treatment setting and documentation is included regarding attempt/failure at a lower level of care.
2. Child has a problem in at least two of three following areas: school behaviors, home behaviors, and community behaviors. Behaviors might include: Temper tantrums, aggression, suspension from school, demands constant attention at home or school, unable to function adequately at home or school, withdrawal.
3. Child would benefit from the intensive focus of the program and from a multi disciplinary approach to treatment and education.
4. Day Treatment services can reasonably be expected to meet the child's needs so that the treatment will be successful. Success in this context means that the child can return to their home school (with outpatient behavioral health support as needed) in a transition plan designed by the Child and Family/Wraparound Team.
5. Client's referral packet includes:
    - Indication that client meets Level IV criteria via the CASII, or ECSII
    - Educational Records which may include: An Individualized Education Plan, Individualize Family Support Plan, 504 Plan, Personal Education Plan (PEP), and/or other assessment as required by the Department of Education.
    - A mental health assessment completed by a QMHP, which includes a completed five axis, DSM IV diagnosis covered by OHP.
6. Local County Mental Health's ISA representative in partnership with the Community Care Coordination Committee pre-authorizes admission.
7. Client must be OHP eligible.

Continued Stay Criteria: *All of the following criteria are necessary for continuing Day Treatment:*

1. The child/adolescent's condition continues to meet admission criteria at this level of care.
2. The child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Childs behavior continues to be unmanageable at a lower level of care; i.e., child is often placed in a safe room, requires physical restraint, has outburst of destructive behavior and aggression, has had numerous holds, has temper tantrums, aggression, demands constant attention at home or school, unable to function adequately at home or school, is withdrawn etc. This behavior occurs either in the classroom, in the treatment environment, or in both settings.
4. The child/adolescent and family are actively participating in treatment.

Transition Criteria: *Any of the following criteria are sufficient for transition from Day Treatment:*

1. The child/adolescent's documented treatment plan goals and objectives have been substantially met and/or the individual no longer meets admission criteria, or meets criteria for a less or more intensive level of care.
2. Behavioral symptoms secondary to the psychiatric diagnosis have decreased to a level where there is no immediate risk of out-of -school placement.
3. The child/adolescent appears able to remain stable with a less intense level of services including routine outpatient care, physician-prescribed medications as needed, community-based support, and educational programming as needed.
4. The child/adolescent exhibits severe disruptive or dangerous behaviors (e.g., suicide/homicide attempt, drug/alcohol addiction, and symptoms of psychosis) that require stabilization at a more intensive level of care.
5. The child/adolescent, family, guardian, and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.
6. Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/legal guardian has the capacity to make an informed decision and the child/adolescent does not meet criteria for a more intensive level of care.
7. The child/adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress in continued Day Treatment.
8. Child demonstrates an ability to attend public school on a part time basis.

ISA/ICTS Referral and Determination

Referrals for a Level of Service Intensity Determination Screening are accepted from multiple sources including families or legal guardians, school personnel, allied agencies, community partners, or physical or behavioral health providers. Referrals may be initiated by telephone or in writing to that person designated by County Mental Health.

The process for referral shall include:

1. An Authorization to Release Information form signed by the parent or legal guardian.
2. A face to face screening to assert that there is a mental health diagnosis.
3. Orientation of the child and family to the services and supports of the local systems of care and agreement by the family that they are interested and invested in having central involvement in the process.
4. Administering of the CASII, (Child and Adolescent Service Intensity Instrument), or ECSII, (Early Childhood Service Intensity Instrument - for children 5 and younger) will occur if clinically indicated and there is evidence that the severity of issues would cause the client to score at level 4 – 6 on the CASII or ECSII.
5. A decision made with the family as to whether the child would benefit from ISA/ICTS if the client scores as a Level 4 – 6 on the CASII or ECSII, (Exceptions can me made for clients who score less than a level 4 on the CASII or ECSII but have factors which indicate that the ICTS process will be helpful and County Behavioral health has sufficient capacity and resources available).
6. A Referral for ISA/ICTS Services is completed. The Referral contains:
   - CASII or ECSII Data Form
   - A mental health assessment completed within 60 days
   - Evidence that the client has a DSM IV Diagnosis covered by OHP
7. An ISA determination will be made based on:
   - The clients score on the CASII or ECSII;
   - A mental health diagnosis covered by OHP
   - The family/guardians agreement to participate in the process
   - Additional prioritizing factors
8. ISA/ICTS determinations will be made with in **3 working days** of completed ISA referral. The family will be participants in the ISA/ICTS determination and will be provided information and support in making decisions regarding treatment and support options.
9. County Behavioral health shall prioritize children with the with the most serious mental health needs for ISA/ICTS taking into consideration prioritization factors including:
   - exceeding usual and customary services in an outpatient Setting;
   - multiple agency involvement;
   - history of one or more out-of-home placements;
   - significant risk of out-of-home placement;
   - frequent or imminent admission to acute inpatient psychiatric hospitalizations or other intensive treatment services;
   - caregiver stress;
   - school disruption due to mental health symptomatology;
   - elevating or significant risk of harm to self or others; or
   - for children birth to 5:
     - history of abuse or neglect;
     - conditions interfering with parenting, such as poverty, substance abuse, mental health problems, and domestic violence, and

- significant relationship disturbance between parent(s) and child.

Outpatient

Positive criteria:

The patient has a psychiatric disorder consistent with the diagnostic nomenclature of the DSM IV.[1]

AND

Treatment is likely to result in either:

- demonstrable improvement in the signs and symptoms of a psychiatric disorder

OR

- the prevention of demonstrable deterioration

AND

The proposed treatment method and frequency is consistent with:

- national standards of treatment and
- Evidence Based Practice guidelines on treatment effectiveness for the specific psychiatric condition and diagnosis of the patient.

Criteria which generally excludes client participation in outpatient services:

- The treatment of long-standing, pervasive, maladaptive traits and/or behavior patterns which are not associated with a current Axis I diagnosis.
- Treatment which has as its main goal: personal growth, greater happiness, personal fulfillment etc.
- Treatment which has not been effective in helping the client to achieve treatment plan goals.
- Treatment frequency of more than one session per week, unless the patient's psychiatric illness or condition requires greater intensity to be effective. Not all patients meet criteria for high risk case management but may need more contact (e.g. DBT clients)
- Psychological services that are primarily educational or geared to self-improvement; assertiveness training; communication skills, etc.

Psychological testing:

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[1] V-codes are acceptable as long as the covered member has a numbered diagnosis in addition to a V-code diagnosis.

Authorization of psychological testing depends upon three major factors: extent of services covered, medical appropriateness of testing, and appropriateness of the specific psychological tests.

Coverage exclusions:

The assessment of certain clinical issues through testing is not a covered benefit. These include but are not limited to:

a) testing to satisfy the demands of outside agencies (courts, state agencies, etc.).
b) educational testing (e.g., for educational placement or school services or for diagnosing learning disabilities). Public schools are responsible for such assessment of children under IDEA.
c) measures of functioning secondary to an established neurological diagnosis (e.g. dementia) as such a testing is covered under the medical benefit.
d) forensic evaluations, including competency to stand trial, Workers Compensation, disability and personal injury evaluations.
e) career or job-related testing such as job placement or career interests.
f) to diagnose or evaluate the intelligence of those with Mental Retardation.
g) research.

Medical appropriateness:

Testing is appropriate only when the following criteria are met:

- There is a specific clinical question to be answered or issue to be resolved.
- The issue directly impacts the form and/or extent of treatment in a timely way.
- The question cannot or has not been answered through a comprehensive clinical evaluation (interview, etc.) or by referral to an appropriate medical specialist (e.g., psychiatrist, neurologist).
- There are valid test instruments available that can directly address the clinical issue.
- The basic adequacy of the patient's functioning (occupational, interpersonal, self-care) is in jeopardy.
- Other than checklists, psychological testing may be performed only by licensed psychologists.

ABHA policy is to deny authorization for testing solely for:

a) routine evaluations.
b) establishing a baseline for future assessment.
c) screening (e.g., for nursing homes).
d) confirmation of diagnosis.
e) to obtain data purely for increased understanding of the member's intrapsychic conflicts.
f) differential diagnosis. Diagnoses are ultimately made by clinicians and not by tests. Most diagnostic questions can be answered by further observation, evaluation and/or consultation. For testing to be authorized, the clinician must demonstrate that other assessment approaches are inadequate to resolve the diagnostic question at hand, and that discerning a particular diagnosis will have a practical impact on treatment.

Appropriateness of psychological tests

For psychological tests to be authorized the following should be considered:

- Each test must have acceptable reliability and demonstrated validity <u>for the specific clinical issue being addressed.</u> Before testing can be considered appropriate, the

effect of potential erroneous results (e.g., unnecessary testing, worry, and unfounded reassurance) must be taken into account.
- Each test must be appropriate for the setting and member (age, gender, and culture).
- Use of the test is the standard of practice in the psychological community.
- The most cost-effective and time-effective tests are to be utilized.

Specific Clinical Issues

In addition to the factors noted above, there are additional considerations for specific clinical issues.

Attention Deficit Disorder (with or without hyperactivity)

- Testing would only be appropriate if the proper use of interview and observational checklists have been inconclusive. Even then, only limited assessment of attention would be authorized.
- Testing to resolve concerns about inattention as symptomatic of learning disabilities or level of intelligence is not covered, but may be available through the school system or the Developmental Disabilities Services Division.
- Neuropsychological batteries are unnecessary unless there is reason to believe that a genuine neurological disorder is present. Assessment of neurological disorders is available through the member's medical plan.

Dementia

- Dementia is diagnosed by a physician, typically either a primary care physician or a neurologist. Therefore, members suspected of having dementia must be evaluated by a physician. If, after that evaluation, the physician believes neuropsychological testing would be appropriate, the testing may be authorized under the medical benefit.
- Likewise, assessment of daily functioning, prognosis and level of care may be considered a medical benefit issue.
- Testing may be authorized for members with dementia who also have a psychiatric diagnosis or when there is differential diagnosis issue (e.g., Depression vs. Dementia).

Intelligence, Achievement and Cognitive functioning

- Assessment of cognitive abilities in general (memory, concentration, learning ability, abstract reasoning, perceptual motor functioning, etc.) will be authorized only if the results would have a direct impact on mental health treatment and alternative evaluation methods (interviews with relatives and coworkers, observation, etc.) are not sufficient.
- Testing is not covered for addressing concerns related to learning disabilities, school achievement or level of intelligence. Such assessments may be available through the school system under IDEA, or through the Developmental Disabilities Service Division.

Personality

- Assessment of normal range personality is not authorized because it does not have a direct impact on the form or extent of treatment.
- Assessment for personality disorder is also rarely authorized because personality change is not the goal of problem focused, goal-directed treatment.

Suicide risk

- Risk of suicide is best evaluated clinically. In rare cases, use of checklists may be authorized. General psychological testing (e.g., MMPI) is not necessary for this issue.

Interpersonal / marital relationships

- Clinical evaluation and observation are the most valuable techniques for assessing this issue. Testing will only be authorized if it can be demonstrated that treatment of the individual's covered mental health diagnosis will be effected.