

**BLUE CARE NETWORK
UTILIZATION MANAGEMENT CRITERIA
FOR
TRANSCRANIAL MAGNETIC STIMULATION (TMS)
CRITERIA/GUIDELINES
NEUROFEEDBACK TRAINING CRITERIA FOR
ADD/ADHD ADMISSION CRITERIA
AUTISM SPECTRUM DISORDER APPLIED BEHAVIOR
ANALYSIS ADMISSION CRITERIA
RESIDENTIAL MENTAL HEALTH SERVICES ADULT,
ADOLESCENT, AND CHILD ADMISSION CRITERIA**

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INTRODUCTION

Treatment for mental health and substance abuse/chemical dependency conditions is covered when the treatment is medically necessary and when it falls within the scope of the member's benefit certificate. Note that the benefit certificate may vary between members.

Note the following GENERAL EFFICIENCY CRITERION which applies to all services: services shall be limited to the most efficient method and scope of treatment that will adequately meet the member's clinical needs.

Services must be reviewed and approved/authorized by Blue Care Network and will be provided by a Blue Care Network practitioner or organizational provider.

All attempts will be made to coordinate the most appropriate level of care and intensity of service for members. This includes transition of members to other levels of care when benefits end.

Throughout this document the term "DSM" is defined to mean the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

TRANSCRANIAL MAGNETIC STIMULATION (TMS) CRITERIA/GUIDELINES

Note: At all levels of care, court ordered treatment or attempts to avoid legal consequences, to prepare for legal defense, or to escape home/work problems, are not deemed sufficient criteria for treatment. There is insufficient evidence regarding the use of TMS in children for its use to be recommended.

Transcranial magnetic stimulation must be administered by an approved U.S. Food and Drug Administration (FDA) cleared device for the treatment of major depressive disorder (MDD) according to specified stimulation parameters, 5 days a week for 6 weeks (total of 30 sessions), followed by a 3-week taper of 3 TMS treatments in 1 week, 2 TMS treatments the next week, and 1 TMS treatment in the last week.

Each of the following criteria is met:

1. Has a confirmed diagnosis of severe major depressive disorder (single or recurrent episodes) without psychosis measured by evidence based scales such as Beck Depression Inventory (score 30-63), Zung Self-Rating Depression Scale (>70), PHQ-9 (>20), or Hamilton Depression Rating Scale (>20)
2. The member is between 18 and 70 years of age
3. A Urine Drug screen is obtained if indicated by current clinical history or a high degree of clinical suspicion
4. At least one of the following:
 - a) Medication treatment resistance during the current depressive episode evidenced by a lack of a clinically significant response to 4 trials of psychopharmacologic agents. Trial criteria is 6 weeks of maximal FDA recommended dosing or maximal tolerated dose of medication with objectively measured evaluation at initiation and during the trial showing no evidence of response (i.e., < 50% reduction of symptoms-or scale improvement).
 - Lack of a clinically significant response to 4 trials of psychopharmacologic agents. Trial criteria is 6 weeks of maximal FDA recommended dosing or maximal tolerated dose of medication with objectively measured evaluation at initiation and during the trial showing no evidence of response (i.e., < 50% reduction of symptoms-or scale improvement). At least two trials should be augmentation trials and two may be with single agents.
 - Two single agent trials of antidepressants of different classes
 - Two augmentation agent trials with different classes of augmenting agents utilizing either (or both) of the agents in the above single agent trials
 - b) The patient is unable to tolerate a therapeutic dose of medications. A trial of less than one week of a specific medication would not be considered a qualifying trial to establish intolerance. Intolerance is defined as: severe somatic or psychological symptoms that cannot be modulated by any means including but not limited to: additional medications to ameliorate side effects. Examples of somatic side effects include persistent electrolyte imbalance, pancytopenia, severe weight loss, poorly controlled metabolic syndrome or diabetes, as a result of the medication. Examples of psychological side effects of the medication would be suicidal-homicidal thinking/attempts, impulse dyscontrol.

- c) Electroconvulsive therapy would not be clinically superior to transcranial magnetic stimulation (e.g., in cases with psychosis, acute suicidal risk, catatonia or life-threatening inanition rTMS should NOT be utilized)
- 5. Trial of an evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms. (e.g., Becks Depression Inventory, Zung Self-Rating Depression Scale, PHQ-9, or Hamilton Depression Rating Scale)
- 6. The following conditions are continuously present in the rTMS treatment setting during treatment:
 - a) An attendant trained in BCLS, the management of complications such as seizures, as well as the operation of the equipment, must be present at all times
 - b) Presence of adequate resuscitation equipment including, for example, suction and oxygen
 - c) The facility must maintain awareness of response times of emergency services (either fire/ambulance or “code team”), which should be available within five minutes. These relationships are reviewed on at least a once a year basis and include mock drills.

Requests for repeat rTMS therapy in patients who have attained remission subsequent to initial rTMS therapy and experienced relapse will be reviewed for individual consideration.

Exclusions:

1. All other behavioral health, neuropsychiatric or medical conditions (e.g., anxiety disorders, mood disorders, schizophrenia, Alzheimer’s, dysphagia, seizures).
2. Pregnancy
3. Maintenance treatment
4. Presence of psychosis in the current episode
5. Seizure disorder or any history of seizure, except those induced by ECT, isolated febrile seizures in infancy without subsequent treatment or recurrence
6. Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 centimeters from the TMS magnetic coil or other implanted metal items, including but not limited to a cochlear implant, implanted cardioverter defibrillator, pacemaker, vagus nerve stimulator, or metal aneurysm clips or coils, staples, or stents. Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS
7. If the patient (or, when indicated) the legal guardian is unable to understand the risk and benefits of TMS and provide informed consent
8. Presence of a medical or co-morbid psychiatric contraindication to rTMS
9. Patient lacks a suitable environmental, or social and/or professional support system for post-treatment recovery

10. There is not a reasonable expectation that the patient will be able to adhere to post-procedure recommendations
11. Caution should be exercised in any situation where the patient's seizure threshold may be decreased.
Examples include:
 - a) Presence in the bloodstream of a variety of agents, including but not limited to tricyclic antidepressants, clozapine, antivirals, theophylline, amphetamines, PCP, MDMA, alcohol, cocaine as these present a significant risk
 - b) Presence of the following agents, including but not limited to SSRIs, SNRIs, bupropion, some antipsychotics, chloroquine, some antibiotics, some chemotherapeutic agents as they present a RELATIVE risk and should be considered when making risk-benefit assessments
 - c) Withdrawal from alcohol, benzodiazepines, barbiturates and chloral hydrate also present a strong relative hazard

NEUROFEEDBACK TRAINING CRITERIA FOR ADD/ADHD

ADMISSION CRITERIA

Note: At all levels of care, court ordered treatment or attempts to avoid legal consequences, to prepare for legal defense, or to escape home/work problems, are not deemed sufficient criteria for treatment. Neurofeedback training for other central nervous system (CNS) disorders, such as autism spectrum disorder, substance abuse, epilepsy, and insomnia, is experimental/investigational. There is a lack of evidence in the peer reviewed published medical literature on the clinical utility and effectiveness of neurofeedback for these conditions.

Delivery: Neurofeedback training services are to be provided in regularly scheduled sessions usually occurring 4-5 times per week. A typical course of treatment is at least 20 sessions and commonly a course of 30 is needed for maximal benefit. Number of visits will be authorized based on medical necessity.

Each of the following criteria is met:

1. The member has the following diagnosis, the symptoms and functional impairment of which are the targets of Neurofeedback training:
 - a) ADD/ADHD
2. The index condition is the primary cause of the member's symptomatology and functional impairment.
3. The degree of symptomatology and functional impairment experienced by the member because of their index condition is characterized by at least one of the following:
 - a) It is moderate or severe.
 - b) It is moderate and long standing (e.g., symptoms have been present for years.)
 - c) It is unresponsive to behavioral, dietary, and medical interventions.
4. The member has had a vigorous evidence based evaluation to support the accuracy of the diagnosis. This diagnosis must be made by an independent outside provider before referring to the treating facility and prior to the start of neurofeedback services and each of the follow must be met:
 - a) Meets the criteria for ADD/ADHD diagnosis using the current Diagnostic and Statistical Manual.
 - b) Has had a diagnostic interview with parents, school representatives and had sufficient examination to document the criteria for diagnosis.
 - c) Psychological testing has been done to confirm the diagnosis (i.e. Conners, Vanderbilt, Test of Variables of Attention (TOVA) or other psychological/neuropsychological testing.)
 - d) Medical evaluation has occurred that is sufficient to exclude a medical cause for the symptoms.

NEUROFEEDBACK TRAINING CRITERIA FOR ADD/ADHD
CONTINUED STAY CRITERIA

Note: At all levels of care, court ordered treatment or to prepare for legal defense are not deemed sufficient criteria for treatment.

1. The member continues to meet admission criteria for neurofeedback training services.
2. There has been measurable, observable improvement in the target symptoms/behaviors.
3. The member is voluntarily and actively participating in face-to-face neurofeedback sessions and demonstrates satisfactory compliance with treatment recommendations. For example, following through on performing homework assignments, consistently attending outpatient appointments, etc.
4. Family consultations must be an active part of training services.
5. The Treatment Plan reflects each of the following:
 - a) Care is being rendered in a clinically appropriate manner and is focused on member outcomes as described.
 - b) The treatment promotes self-efficacy and independent functioning
 - c) A change in diagnosis or in treatment modality is accompanied by clinical data that sufficiently justifies the change.
6. The Treatment Plan contains each of the following elements:
 - a) Defined and behaviorally measurable goals.
 - b) Expected and reasonable timeframes for goal achievement.
 - c) A psychiatric referral for conditions for which psychotropic medications have demonstrated efficacy. For example, when training is not achieving a response and minimal progress in the first 20 sessions.
 - d) Anticipated changes in the treatment plan when goals are being met or if goals are not achieved. This may include a request for another independent evaluation if the member is making little to no progress in their treatment plan.

NEUROFEEDBACK TRAINING CRITERIA FOR ADD/ADHD
DISCHARGE CRITERIA

Note: At all levels of care, court ordered treatment or to prepare for legal defense are not deemed sufficient criteria for treatment.

Neurofeedback Training should be discontinued if any of the following criteria is met:

1. Remission of symptoms has been achieved.
2. Improvement has reached a plateau over one week of successive treatments.
3. Twenty (20) treatments have been delivered and measurable improvement has not yet been achieved.
4. The member is assessed as no longer meeting the DSM Diagnostic criteria for Mental Disorders.
5. The member has completed treatment goals and objectives.
6. The member is able to maintain pre-morbid level of functioning.
7. The member has failed to achieve treatment goals and objectives despite revisions in treatment plan and symptoms warrant the use of another level of care, different treatment setting or treatment modality.
8. The member's level of functioning is not expected to significantly decline upon termination of therapy.

OUTPATIENT MENTAL HEALTH SERVICES
AUTISM SPECTRUM DISORDER
APPLIED BEHAVIOR ANALYSIS
ADMISSION CRITERIA

Note: At all levels of care, court ordered treatment or to prepare for legal defense are not deemed sufficient criteria for treatment.

In State Admissions:

Each of the following criteria is met:

1. The member has had an evaluation at a BCN Approved Autism Evaluation Center (AAEC) within the three years prior to the initiation of treatment.
2. The member has a diagnosis of Autism Spectrum Disorder as a result of the AAEC evaluation.
3. Applied Behavior Analysis (ABA) treatment was recommended as an outcome of the AAEC evaluation.

Out of State Admissions:

A multidisciplinary autism evaluation must take place in order for a member residing out of state to access Applied Behavior Analysis (ABA) treatment services.

The parent/guardian must complete the following:

1. Take the checklist and information below to their child's health care provider.
2. Ensure that the providers who perform the multidisciplinary autism evaluation document a comprehensive set of treatment recommendations for their child, including a recommendation for applied behavior analysis.
3. Give all evaluation documentation and treatment plan recommendations to a board-certified behavior analyst who participates with the Blue Cross plan in the state where the services will be provided.
4. Make sure that the recommended treatment is approved by a Blue Care Network behavioral health care manager before treatment begins so that applied behavior analysis benefits are covered.

Getting the multidisciplinary autism evaluation:

Where can an approved multidisciplinary autism evaluation take place?

- The multidisciplinary autism evaluation must be completed at an academic medical center or a hospital-based facility.
- The facility must participate with the Blue Cross plan in the state where the member's services will be provided.

Who performs the multidisciplinary autism evaluation?

A team of specialists with significant experience diagnosing and treating autism spectrum disorders participates in a multidisciplinary team meeting (which may occur electronically). The meeting is held to discuss the results of the multidisciplinary evaluation. The team must include all of the following:

- A board-certified pediatrician, developmental pediatrician or pediatric neurologist
- A fully licensed pediatric neuropsychologist, board-certified child psychiatrist or fully licensed child psychologist
- A speech and language therapist
- A qualified/trained professional who can perform an Autism Diagnostic Observation Scale, or ADOS

What's needed for the multidisciplinary autism evaluation (checklist)?

The evaluation must adequately assess behavior, communication, and social interaction and include:

- Autism Diagnostic Observation Scale, or ADOS (required)
- History and physical examination
- Psychiatric evaluation
- Speech pathologist evaluation

Access is necessary to these other studies as needed:

- Imaging studies
- EEG
- Metabolic and genetic testing

In addition to the required tests above, at least **one** of the following must be performed:

- ADI-R: Autism Diagnostic Interview, Revised
- CARS: Childhood Autism Rating Scale, 2nd Edition
- SCQ: Social Communication Questionnaire, Current/Lifetime version
- GARS: Gilliam Autism Rating Scale

What's needed for the member to be approved for ABA benefits?

For members to obtain the Michigan-mandated applied behavior analysis benefit for Blue Care Network, the following are required:

- A diagnosis of autism spectrum disorder from the multidisciplinary team:
- A recommendation for treatment including applied behavior analysis
- Approval for applied behavior analysis from Blue Care Network behavioral health care manager
- To provide quality care for members and to meet adjudication timeframes, the Medical Director can authorize ABA treatment if criteria outlined in the medical policy titled “Management of ABA requests for Autism Spectrum Disorder - Effective 6/10/15” meets clinical evaluation criteria for medical necessity.

Recommendations for treatment may include

- Applied behavior analysis
- Speech therapy
- Occupational therapy
- Physical therapy
- Nutritional counseling
- Social skills
- Parent education/support
- Behavioral health services (psychotherapy, psychiatry, medication, management)
- Other

OUTPATIENT MENTAL HEALTH SERVICES
AUTISM SPECTRUM DISORDER
APPLIED BEHAVIOR ANALYSIS
CONTINUED STAY CRITERIA

Note: At all levels of care, court ordered treatment or to prepare for legal defense are not deemed sufficient criteria for treatment.

1. Continues to meet the criteria for admission to Autism Spectrum Disorder treatment protocol.
2. Clear identified specific domains of treatment are identified as the focus of intervention.
3. Skill deficits in the identified specific domain are identified and targeted interventions are proposed that can be longitudinally measured:
 - a) Pre-academic skills
 - b) Safety skills
 - c) Social Skills
 - d) Play or Leisure skills
 - e) Community integration
 - f) Vocational Skills
 - g) Coping and tolerance skills
 - h) Adaptive and self-help skills
 - i) Language and communication skills
 - j) Attending skills
 - k) “inappropriate” behaviors
4. An update of the Autism Social Skills Profile, Social Skills Rating System, or Social Skills Checklist (or similar scale that has evidence to base its validity that has been identified at baseline evaluation) is completed no less frequently than every six months and shows expected progress, or; expected progress has not been demonstrated and the treatment plan has been modified accordingly.
5. Blue Care Network may require a 3-year multidisciplinary re-evaluation in cases where a member has shown only minimal progress or when there is a significant question about the continued accuracy of a member’s diagnosis or treatment plan. BCN may also require that a member undergoes annual developmental testing as a standardized method of measuring treatment progress.

6. The treatment plan specifies precisely what improvement is expected within the next measurement interval, at most 6 months.
7. The member has shown improvement in the focused ABA therapy in the measurement interval at most 6 months, of at least 10 percent based on objective measurements recorded frequently during the course of the interventions.
8. There is support system involvement in the therapy that is active and engaged in a manner that is constructive to facilitate improvement in the social interaction of the member
9. Support systems are compliant with the interventions including PCP visits, ABA therapy, Psychiatric recommendations including medication adherence if indicated, family counseling, and or individual counseling.
10. The proposed treatments going forward adhere to current “National Standards Report, National Autism Center” guidelines. Any treatment proposed outside these guidelines would need at least level “B” evidence to support authorization of this proposed intervention.
 - a) Clear identification of the “package’ or strategy would need to be identified at the time of the authorization.
 - b) Subsequent assessments based on progress within that “curriculum’ to its completion/ or maximization of benefit (plateau/new baseline).
11. Identifying appropriate setting for the use of interventions in which they occur, beyond this list clear and convincing reasons would need to accompany authorization;
 - a) Home
 - b) Clinic/outpatient
 - c) Community setting
12. At least yearly the baseline testing used for the diagnose is repeated and reported, if no change it needs to be repeated in 6 months and if again no change likely the member is not benefitting from this level of care/intervention and this course of treatment needs to be discontinued as being ineffective.

OUTPATIENT MENTAL HEALTH SERVICES
AUTISM SPECTRUM DISORDER
APPLIED BEHAVIOR ANALYSIS
DISCHARGE CRITERIA

Note: At all levels of care, court ordered treatment or to prepare for legal defense are not deemed sufficient criteria for treatment.

1. One or more of the following criteria must be met:
 - a) The member no longer meets the criteria for ASD.
 - b) The member has completed treatment goals and objectives.
 - c) The member has failed to achieve treatment goals and objectives despite revision in their treatment plan and symptoms warrant another level of care or different treatment setting.
 - d) The member's symptom level and functional impairment are not expected to improve significantly as a result of the proposed treatment and treatment progress has plateaued.
2. One or more of the following criteria must be met:
 - a) The member's level of functioning is not expected to significantly decline upon termination of therapy.
 - b) The member's parent and/or guardian as been trained in ABA principles to maintain social function.

RESIDENTIAL MENTAL HEALTH SERVICES
ADULT, ADOLESCENT, AND CHILD
ADMISSION CRITERIA

Note: At all levels of care, court ordered treatment or attempts to avoid legal consequences, to prepare for legal defense, or to escape home/work problems, are not deemed sufficient criteria for treatment. For inpatient and residential levels of care lack of adequate housing is not sufficient criteria for admission or continued stay. Also, the criteria in this section do not apply to cases of substance use disorders. Other sections within this document contain criteria specific to these disorders.

General description: Residential treatment is a level of care that can be accessed as an alternative to inpatient hospitalization or as a step-down level of care from inpatient treatment. Residential treatment is only appropriate for persons who do currently need treatment in a 24-hour protected environment yet will benefit from intense interventions to improve function at the level of partial hospital programming but for some clinical reason cannot be safe in that environment.

Definition: A medically managed facility that provides 24-hour care, seven days a week. Residential treatment takes place in a structured facility-based setting. Wilderness programs are not considered residential treatment.

The facility must be able to provide the level of supervision and treatment as described below as well as meeting the patient's domiciliary necessities (room and board).

Program Requirements

1. A FACE to FACE evaluation by the *attending psychiatrist must* occur within 48 hours of admission.
2. The program must provide supervision seven days per week/24 hours per day. Nursing or other equivalent-level psychiatric care is on-site or on call and able to reach the facility within 60 minutes, 24 hours a day, seven days a week. A psychiatrist is on-call 24/7. A psychiatrist is on site a minimum of two days per week.
3. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. An initial treatment plan should be developed within 72 hours of admission and a more robust treatment plan should be developed by the end of week two. Treatment plans should be updated at least weekly. This plan includes the following elements at a minimum:
 - a) FACE to FACE family therapy/meeting with the patient and caretakers'/guardians'/family members' involvement should occur weekly, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
 - b) Medication management by a board certified psychiatrist must be provided a minimum of twice per week.
 - c) There must be ongoing medical services to evaluate and manage co-morbid medical conditions,
 - d) Integrated treatment, rehabilitation and support must be provided by a multidisciplinary team. There should be linkage and/or coordination with the patient's community

resources with the goal of returning the patient *to* his/her regular social environment as soon as possible.

- e) A certified educational program for facilities serving children and adolescents.
4. There should be individual therapy twice per week.
 5. Group therapy should comprise a **minimum** of 12.5 hours per week.
 - a) Groups should be between 60 and 90 minutes in length.
 - b) At least two group therapies sessions should be “psychological” sessions such as process groups and/or DBT.
 - c) The remaining groups may be expressive, such as art/dance/psychodrama therapy, and/ or psychoeducational.
 - d) Recreational activities should be available to those able to participate and there should be a minimum of four hour of treatment/activities planned each weekend day.
 - e) Therapies such as equestrian therapy or “ropes” exercises may be included but not at any additional cost to the member. Wilderness programs are excluded
 - f) Clinical judgment should be used to determine whether the patient can tolerate the amount of group activity; if the patient is unable to participate to the extent described above, the reason should be documented in the chart for each activity.
 6. There should be a minimum of four hours of treatment/activities planned each weekend day. Therapies such as equestrian therapy, “ropes” exercises may be included but not at any additional cost to the member. Wilderness programs are excluded.
 7. For geriatric facilities, the care is expected to include availability of activities/resources to meet the social needs of older patients with chronic mental illness. These needs would typically include at a minimum company (either visitors or individuals inside the facility), daily activities and having a close confidant.

Each of the following criteria is met:

1. The member receives a clinical evaluation by a Blue Care Network practitioner and meets the diagnostic criteria for a DSM non-V Code psychiatric disorder as defined by the DSM.
2. Due to their psychiatric illness or an acute exacerbation of their chronic psychiatric illness, the member meets one or more of the following criteria:
 - a) The member is clearly dangerous to him/her self or others. This risk of harm is evidenced by a recent suicide attempt or assault and/or by active intent to seriously injure self or others. Chronic or lifestyle danger (e.g., unprotected sex, promiscuity, driving under the influence or drug use) does not, in and of themselves, represent clear and imminent risk.
 - b) The member’s mental status is impaired such that the member cannot adequately care for him/her self or maintain a safe environment outside of a 24-hour supervised setting. Corresponding objective mental status findings must be documented.

- c) There should be evidence base to support a reasonable expectation that the illness, condition, or level of functioning will be stabilized and improved, and that a short-term, sub-acute residential treatment service will have a likely benefit on the behaviors/symptoms that required this level of care, and that the covered individual will be able to return to outpatient level of care.

And each of the following criteria is met:

- d) The proposed treatment is appropriate and consistent with any applicable BCN treatment policies and the standard of care.
- e) The intensity of service is commensurate with the member's reported dangerousness and their reported need for 24-hour medical supervision.
- f) Unless contraindicated, family members participate in development of the treatment plan, participate in family program and groups and receive family therapy at least once a week,
- g) Objective measurable scales are used upon admission to establish a baseline compared to which measurable improvement is based appropriate to the admission diagnosis (i.e. Becks/Zung for depression, YBOCS for OCD, etc.)

Special consideration for Eating Disorders afflicted members:

1. Members with Anorexia Nervosa: have metabolic parameters to assess nutritional status that are sufficiently manageable to allow them to utilize the therapeutic interventions for a positive benefit.

As example:

- a) There is non-critical evidence of malnutrition, marasmus, or kwashiorkor that would interfere with their mental capacity to participate in the therapeutic modality.
- b) The member is typically between 80-90% of expected body weight or an equivalent accepted physiologic/objective measure positive. If less than this or an accepted equivalent physiologic/objective measure positive, objective clinical evidence needs to be reviewed as to the appropriateness of the member to participate in a meaningful way in the psychotherapeutic environment to their benefit. (Note: appropriate patients under 80% of expected body weight or the equivalent accepted physiologic/objective measure positive are likely to require extended treatment time, and may not benefit from this level of care.)

Positive examples of “equivalent accepted physiologic/objective measure” might be:

- i. Sex hormone binding index has started to return to normal
 - ii. Prealbumin has stabilized or improving.
 - iii. The Protein Energy Malnutrition Scale (PEMS) score suggests no severe evidence of malnutrition.
2. The member (or home support system) has the capacity to reliably attend and actively participate in the treatment plan.

RESIDENTIAL MENTAL HEALTH SERVICES
ADULT, ADOLESCENT, AND CHILD
CONTINUED STAY CRITERIA

Note: At all levels of care, court ordered treatment or attempts to avoid legal consequences, to prepare for legal defense, or to escape home/work problems, are not deemed sufficient criteria for treatment. For inpatient and residential levels of care lack of adequate housing is not sufficient criterion for admission or continued stay. Also, the criteria in this section do not apply to cases of substance use disorders. Other sections within this document contain criteria specific to these disorders.

Each of the following criteria is met:

1. The member continues to meet residential admission criteria.
2. The member and social support structure is participating actively in their treatment.
3. The treatment plan meets accepted clinical standards of care, is consistent with any applicable BCN treatment guidelines, and is adequate to address the patient's condition; significant improvement can be anticipated.
4. A discharge plan is completed within one week that includes who the outpatient providers will be and where the covered individual will reside.
5. The treatment is individualized and not determined by a programmatic timeframe. It is expected that covered individuals will be prepared to receive the majority of their treatment in a community residential setting.
6. Medication evaluation and documented rationale if no medication is prescribed.
7. Measurable improvements on any objective measures completed upon admission. If none, reasons for the lack of progress and a clear change of treatment plan to address the lack of progress. Two weeks in a row of minimal or no improvement would be reason to reconsider level of care.

Additional criteria for children and adolescents include: The member's social support structure is intensively involved in face-to-face treatment, unless legal restrictions or clinically valid barriers prevent such treatment (i.e. family meetings or therapy at least twice weekly in person would be expected.)

Special consideration for Eating Disorders afflicted members:

1. Member is stable or gaining weight is not exhibiting severe thought disorder or obsessive thinking that is not being addressed actively.
2. Member is not exercising excessively negating any improvement in their oral intake
3. Member is cooperating fully with the refeeding protocol if any being prescribed, (i.e. not pulling out feeding tube, working actively with staff to consume the prescribed calories.)

RESIDENTIAL MENTAL HEALTH SERVICES
ADULT, ADOLESCENT, AND CHILD
DISCHARGE CRITERIA

Note: The criteria in this section do not apply to cases of substance use disorders. Other sections within this document contain criteria specific to these disorders.

Each of the following criteria is met:

1. The member no longer meets continued stay criteria for this level of care.
2. The member is assessed as being able to adequately function at a less intensive level of care.
3. The member's risk of self-harm has been assessed. Based on assessment findings the member is either
 - a) Not at significant risk for self-harm or
 - b) Is at significant risk of self-harm but the benefits of treatment continuing at a less restrictive or intensive level of care outweigh the risks of self-harm.
4. A discharge plan is in place that includes identification of specific practitioners, family/social supports and programs for the next level of care required.
5. If chemical dependency has been identified during the stay, a referral to an appropriate treatment program has been made. Please refer to the substance abuse treatment criteria.

Additional criteria for children and adolescents include:

If substance abuse in a family member, especially a caretaker of the member, has been identified during the continued stay, all efforts are made to encourage that person to seek treatment for themselves.

Special consideration for Eating Disorders afflicted members:

Member's weight is generally stable at or above 90% of expected body weight or equivalent accepted physiologic/objective measure that was assessed on admission.

Examples of "equivalent accepted physiologic/objective measure" might be:

- i. Sex hormone binding index has started to return to normal
- ii. Prealbumin has stabilized or improving.
- iii. The Protein Energy Malnutrition Scale (PEMS) score suggests no severe evidence of malnutrition.