



BEHAVIORAL HEALTH LEVELS OF CARE PROGRAM DESCRIPTIONS

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Applied Behavior Analysis (ABA)

Description:

Applied Behavioral Analysis (ABA) therapy is a structured and systematic approach to reduce the intensity, frequency and/or duration of challenging behaviors and increase the use of critical adaptive behaviors for those individuals who have a diagnosis of Autism Spectrum Disorder (ASD). TennCare plans also allow for ABA therapy to be provided to individuals who have diagnoses associated with Intellectual disability and/or traumatic brain injury. Challenging behaviors can include, but are not limited to aggression, property destruction, self-injury (scratching, biting, head-banging), and self-stimulatory behavior which may be repetitive and ritualistic (rocking, pacing, jumping up and down, gazing, lining up objects). Critical adaptive behaviors include, but may not be limited to functional communication skills (e.g., asking for a “break,” pointing to a picture of a desired item or activity), pro-social behavior (e.g., cooperative play, staying on task), completing activities of daily living, eating, and toilet training.

Providers of ABA services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Providers of ABA services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and ABA treatment records will comply with those standards. All applicable Tennessee state mandated requirements of the Tenn. Code Ann. § 56-7-2367 (2016) 56-7-2367. Autism spectrum disorders are also followed by BlueCross BlueShield of Tennessee.

Program Expectations:

- Initial Assessment that includes the following essential components:
 - Demographics and Date of Assessment
 - Reason for Referral
 - Description of Behaviors of Concern in Observable and Measurable Terms
 - Hypotheses Regarding Medical, Psychiatric, and Other Contributions (i.e., ecological) to Problem Behavior (Motivating Operations)
 - Graphed Baseline Data for Target Behaviors
 - Functional Assessment
 - Hypotheses Regarding Functions of Target Behaviors Based on Direct Observations and Interviews of Member and/or Caregivers
 - Identification of Functionally Equivalent Replacement Behaviors/Contingency Management
 - Measurable, Achievable, and Time-Limited Goals and Objectives for Target and Replacement Behaviors
 - Service Recommendations (Units, Frequency, Expected Duration)
 - Risks/benefits/possible side effects/ potential contraindications for recommended approach
 - Justification for any proposed restrictive procedures and a plan to fade them
 - Signature of the licensed BCBA who completed the assessment
- Development of a Behavioral Support Plan (BSP), written in language that is clear and understandable to all implementers of the Plan. The BSP must include:
 - List of Target Behaviors with observable, measurable descriptions
 - Prevention Strategies for each Target Behavior
 - Intervention Strategies for each Target Behavior
 - Teaching Strategies for Replacement Behavior
 - The plan to fade any restrictive procedures
 - Reference to crisis procedures (either developed by the licensed BCBA or those used by the LTSS provider agency) and when to apply them
 - Identification of any behaviors not targeted by interventions but to be tracked for data analysis
 - Data sheets for use by anyone implementing the BSP

- Signature of the licensed BCBA who developed the BSP
- Signature of the member or representative (e.g., guardian, parent, conservator) indicating informed consent for the BSP.
- Caregiver involvement in all phases of treatment is essential. Services will include caregiver observation as well as training and assistance with implementing the approved BSP.
- Progress toward behavioral changes is graphed, analyzed, interpreted and includes: graph titles/captions, appropriately labeled horizontal (x) and vertical (y) axes, graph legends, as well as phase change and event lines.
- Documentation of each service encounter (i.e. progress notes) should include:
 - Date and Time of Service, Units Used
 - Location of Service (e.g., Home, Clinic, School, Community)
 - Type of Service (e.g., Direct Observation, Training, Implementation, Data Gathering & Review)
 - Client Info on Each Page (DOB, etc.)
 - Behavioral Change Objectives/Corresponding Assessment of Progress
 - Adverse Incidents
 - Documentation of Specific Training Provided to Guardians/Caregivers/Teachers
 - Assessment of Effectiveness of Behavioral Support Plan including:
 - Recommendations for Any Adjustments to the Plan along with rationale
 - Recommendations to Continue at Current Level of Support or Increase/Decrease/Discharge along with rationale
 - Barriers/Obstacles to Progress (e.g., inadequate or inconsistent implementation of the BSP, member’s illness, hospitalization, inadequate data tracking by implementers of the BSP)
 - Signature, Date, and Credentials of the Servicing Professional (e.g., BCBA or RBT)
 - Signature and Date of Guardian/Caregiver (if training was provided)
- Coordination of care with all relevant medical and behavioral health providers, as well as other supports in the community (i.e. school, family supports, community agencies, etc.). Service in the school environment should be limited to ensuring consistency in plan implementation across all settings. Service in the school should not include developing a BSP for the school or addressing behavior for academic purposes.
- Discharge planning that begins at admission and will include:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports
 - Safety/crisis planning with involvement of family/other supports
 - Patient and family education regarding patient’s behavior, plan implementation, risk factors and warning signs of relapse
 - Generalization of progress to other settings/situations
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated
 - Referrals for community assistance and support
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of member’s discharge to include admission date, presenting problem, summary of care, the reason for discharge, member’s condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Comprehensive Child and Family Treatment (CCFT)

Definition:

Comprehensive Child and Family Treatment (CCFT) is a model of Level 1 Mental Health Case Management, which provides a team approach for treating children and youth who are at high risk for hospitalization or placement out of the home. CCFT services are high intensity, goal-specific services designed to provide stabilization and deter the imminent risk of out of home placement, including state custody or higher levels of care. CCFT services concentrate on child/family/guardian behaviors and interactions with the goal of reaching an appropriate point of stabilization so the individual can transition to a less intensive outpatient service. CCFT services can be provided in home, community or office-based settings using a frequency appropriate for the intensity and imminent risk presented by the clinical situation, but typically at least three sessions a week. CCFT services are available 24 hours a day, seven days a week. CCFT services can include therapeutic and/or skills training interventions that support improved functioning of the child/youth and the family unit so imminent crises are averted. Services are designed to use and foster individual and family strengths and formal and informal community support.

This intensive care coordination component of CCFT is designed to initially “wrap” families with support but ultimately help families independently navigate systems to meet all formal and informal needs. CCFT services are delivered through a team approach to children with high-risk behaviors and family instability.

CCFT Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. CCFT Programs will also adhere to contractual guidelines in the Provider Administration Manual. Treatment record standards for behavioral health providers are in the Provider Administration Manual. CCFT treatment records will comply with those standards in the Program Expectations outlined below:

Program Expectations:

- Initial screening to evaluate the appropriateness of the client’s participation in the program will occur within three days of referral.
- Develop an individualized treatment plan within one week with updates at least monthly to include evidence of family and child participation in planning.
- Staff is available for 24/7 on-call crisis response.
- Develop individual safety and crisis plans, with evidence of family/caregiver involvement understanding.
- Minimum number of face-to-face contacts is at least three sessions per week as clinically indicated.
- Coordinate care with all relevant medical and behavioral health providers, as well as other supports in the community (e.g., school, family supports, other community agencies, etc.).
- Family education and support.
- Evaluate the need for psychotropic medicine and coordinate management services as needed.
- Individualized, team-based, in-home evidence-informed treatment for behavioral health and substance abuse issues including individual and family approaches.
- A monthly summary is completed specifying the date of face-to-face visits, services provided within the visits, counseling/therapy sessions, and other coordinated services provided as well as documentation of progress toward all treatment goals.
- Discharge planning that begins at admission and will include:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient’s diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assessment of ability to participate in usual school and other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient’s discharge to include admission date, presenting problem, summary of care, reason for discharge, patient’s condition at the time of discharge, all aftercare recommendations, including appointments and signature of the person preparing the summary.

Continuous Treatment Team (CTT) - Adult

Definition:

Continuous Treatment Teams (CTT) are coordinated multidisciplinary teams (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults with Severe and Persistent Mental Illness (SPMI) in an effort to prevent removal from the home to a more restrictive level of care. CTTs are designed to provide flexible, multi-purpose, community-based clinical support for SPMI patients. Interventions are aimed toward strengthening the adult and his/ her family when appropriate in order to provide stability and preservation in the community setting. CTT services address the unique needs of each patient with attention given to cultural values and individual/family strengths, and are available 24/7.

CTTs will adhere to all standards and regulations set forth by their licensing and accreditation entities. CTTs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and CTT treatment records will comply with those standards as well as the Program Expectations - outlined in the following:

Program Expectations:

- Thorough assessment of needs and development of an individualized treatment plan to include the entire CTT team within the first 30 days of service.
- Coordination of care with all relevant behavioral health, medical, and community providers and caregivers
- An array of services including: crisis intervention and stabilization, counseling, skill building, therapeutic intervention, advocacy, psychoeducational services, psychiatric evaluation and medication management as indicated, and other specialized services deemed necessary and appropriate.
- Individualized crisis planning to include the availability of the CTT team 24/7, family and other natural supports, as well as emergency services with evidence of the patient's and/or caregiver's input and understanding
- Discharge planning that begins at admission and will include:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assessment of ability to participate in usual work and other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations, including scheduled appointments and signature of the person preparing the summary.

Continuous Treatment Team (CTT) - Child/Adolescent

Definition:

Continuous Treatment Teams (CTT) are coordinated multidisciplinary teams (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to children and adolescents at risk of higher levels of care or removal from home due to behavioral health concerns. CTTs are designed to provide flexible, multi-purpose, community-based clinical support for children and adolescents with acute psychiatric problems in the context of their family constellations.

Interventions are aimed toward strengthening the child and the child's family in order to provide stability and preservation in the community setting. CTT services address the unique needs of each child/adolescent with attention given to cultural values and individual/family strengths, and are available 24 hours a day, seven days per week.

CTTs will adhere to all standards and regulations set forth by their licensing and accreditation entities. CTTs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and CTT treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Thorough assessment of needs and development of an individualized treatment plan to include the entire CTT team within the first 30 days of service
- Coordinate care with all relevant behavioral health, medical, and community providers and caregivers.
- An array of services including: crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, psychoeducational services, psychiatric evaluation and medication management as indicated, school-based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.
- Individualized crisis planning to include the availability of the CTT team 24/7, family and other natural supports, as well as emergency services with evidence of the patient's and/or caregiver's input and understanding
- Discharge planning that begins at admission and will include:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assessment of ability to participate in usual school and other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Crisis Stabilization Unit (CSU)

Definition:

Crisis Stabilization Units (CSU) provide 24/7 intensive, short-term intervention and stabilization for adults (18 years and older) experiencing a mental health crisis and voluntarily consent to receive services. When less restrictive treatment is not appropriate or available, CSU can be used to prevent further escalation of symptoms associated with a serious mental illness or the need for acute psychiatric hospitalization. The average length of stay in a CSU is three days (72 hours). Per Tennessee Department of Mental Health and Substance Abuse Services licensure rules (Chapter 0940-5-18), CSUs can provide up to 96 hours of short-term stabilization. The licensure rules also state: "If necessary, in order to assure that adequate arrangements are in place to allow for the safe discharge of the service recipient, the length of stay may be extended by up to 24 hours." These services can only be accessed by referral from Mobile Crisis Services or Crisis Walk-in Services.

Crisis Stabilization Units will adhere to all standards and regulations set forth by their licensing and accreditation entities. Crisis Stabilization Units will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Crisis Stabilization Units treatment records will comply with those standards as well as the Program Expectations outlined below:

Program Expectations:

- Documented admission assessment/intake performed by a licensed clinician to determine appropriate level of care and a documented initial physical assessment performed within the first six hours of admission.
- Psychiatric evaluation, medication management and treatment as indicated by the treatment plan are provided by a qualified prescriber, authorized by the Tennessee Board of Examiners or the Tennessee Board of Nursing. If the qualified prescriber is not a psychiatrist, the qualified prescriber must have psychiatric expertise as defined by training, education or experience with consultation available by a psychiatrist.
- The qualified prescriber must be on call 24 hours per day and must make daily rounds.
- At least one registered nurse, nurse practitioner or physician assistant must be on duty and on-site 24 hours per day, seven days per week.
- A designated director or administrator who is responsible for facility management and operations.
- Complete an individualized treatment plan within six hours of admission, based on the individual's initial assessment and designed to resolve the individual's immediate crisis.
- Review the individualized treatment plan at least daily and include the signature(s) of appropriate treatment staff, including the qualified prescriber. The treatment plan review must document progress toward each treatment objectives with revisions, as indicated. The treatment plan review must document status of discharge plans.
- Statement by the staff psychiatrist or physician justifying the level of care must be documented daily including an assessment of suitability for treatment in a less restrictive environment.
- Create and implement an individualized safety plan within the first six hours that includes safety checks at appropriate frequencies.
- Behavioral health services are to be provided by behavioral health staff with expertise appropriate to the individual's needs.
- Discharge planning that begins at admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of appropriate care.
 - A discharge summary documenting diagnoses, medications, readiness for discharge, recommendations and planning for the next level of care, as indicated, and aftercare plans.
 - Safety/crisis planning with involvement of family/other supports, as indicated.
 - Timely and clinically appropriate aftercare appointments scheduled to take place within seven days of discharge date.
 - Prescriptions for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
 - Referrals for community assistance and supports.
 - A comprehensive discharge summary is completed and available in the treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments and signature of the person preparing the summary.

Eating Disorders Inpatient Hospitalization

Definition:

Inpatient Treatment for Eating Disorders provides 24-hour care and monitoring in a contained environment with psychiatric/medical and nursing care for patients with acute symptoms of a diagnosed eating disorder resulting in physiological instability and/or acute risk of harm to self or others. Treatment at this level of care aims to stabilize the acute symptoms to the degree that the patient is able to safely continue care in a less restrictive environment.

Inpatient Eating Disorder programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Inpatient Eating Disorder programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records should comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- A Psychiatric Evaluation is completed by a psychiatrist or MD in consultation with a psychiatrist within 24 hours of admission.
- A Medical Evaluation including weight, cardiac status, metabolic status, vital signs, and relevant lab results completed within 24 hours of admission.
- Develop an individualized treatment plan within 24 hours of admission and updated at least weekly to include a dietary plan, necessary dietary and vitamin supplements, nutritional counseling.
- Daily psychiatric and medical evaluation by a psychiatrist or a licensed prescriber in consultation with a psychiatrist and monitoring with medication management if indicated.
- Daily comprehensive care by a treatment team under the direction of a board-eligible/board-certified psychiatrist.
- Family involvement at every level of treatment including treatment plan development, assessment, therapy and discharge planning.
- Coordinate care/communication with the patient's primary care provider regarding treatments, medications, co-occurring conditions and program outcomes.
- Discharge planning that begins at admission and will include:
 - Recommendations and planning for the next level of care.
 - Preparation for the transition to the next level of care ensuring the patient understands diagnosis/symptoms, dietary plan, warning signs of relapse, treatment and community resources.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Patient/family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assess the patient's ability to participate in usual school, work and other activities.
 - Aftercare planning with a multidisciplinary team, patient and support including follow-up appointment arrangement that takes place within seven days of discharge for the next lower level of care, psychiatric medication management appointments, psychotherapy appointments, nutritional counseling, medical appointments, and/or other social services or community resources as indicated.
 - Medications (psychotropic and physical health medications) or prescriptions in sufficient quantity to last until scheduled appointment with medication management provider.
 - Plan for vitamin and mineral supplements or liquid feeding supplements as needed.
 - Plan for monitoring meals, weight, and trigger thoughts and/or behaviors.
 - Referrals to appropriate self-help or support group.
- A comprehensive discharge summary is completed and available in treatment record within 10 business days of the patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Eating Disorders Intensive Outpatient Program

Definition:

Intensive Outpatient Programs (IOP) for Eating Disorders deliver structured, time- limited, multidisciplinary mental health treatment to individuals with eating disorders that can be safely treated in an outpatient setting. Eating Disorders IOP provides the individual an opportunity to address the stressors that led to the need for treatment as well as an opportunity to learn and use coping skills.

This level of care allows the individual to live in the community without the restrictive environment of a 24-hour residential setting. These programs provide a minimum of at least three hours per day of treatment, two to five days per week and are appropriate for individuals who can safely control their behavior. Eating Disorders IOPs are staffed by mental health professionals with training in the treatment of eating disorders. The range of services may include individual, family, and group psychotherapies, as well as various psychoeducational activities.

Eating Disorder Intensive Outpatient Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Eating Disorder Intensive Outpatient Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual.

Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Eating Disorder Intensive Outpatient Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Program must be under the supervision of a licensed clinician and/or psychiatrist
- Program will include access to a psychiatrist for any needed consultation
- Individualized treatment plan, including pre-discharge planning, is completed within three days of admission into the program and updated at least every eight IOP sessions or more frequently as needed
- Close coordination of care with other relevant healthcare providers such as PCPs, nutritionists, etc.
- The initial assessment, the treatment planning process, as well as the entire course of treatment will include family involvement. Family therapy (face- to-face) is vital to treatment and is expected unless it is contraindicated
- Education for the client and any family or other support persons regarding eating disorders and the recovery process
- Linkage to community resources and supports, including community recovery resources
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports
 - Safety/crisis planning with involvement of family/othersupports
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse
 - Assessment of ability to participate in usual work or other activities
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated
 - Referrals for community assistance and support
 - A comprehensive discharge summary is completed and available in treatment record within 30 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Eating Disorders Partial Hospitalization Program

Description:

A Partial Hospitalization Program (PHP) for Eating Disorders is a nonresidential day treatment program that provides structured, time limited treatment for individuals with acute symptoms of an eating disorder. These individuals should be able to maintain personal safety within the community. Treatment services at this level of care are similar to those provided in an inpatient setting, including medical and nursing services. PHP programs typically occur three to seven days per week and between four and six hours per day. PHP for eating disorders addresses symptoms and behaviors specifically related to eating disorder diagnosis and co-occurring disorders that impact the eating disorder symptoms and behaviors.

Partial Hospitalization Programs for Eating Disorders will adhere to all standards and regulations set forth by their licensing and accreditation entities. PHP programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and PHP treatment records should comply with those standards as well as Program Expectations outlined below:

Program Expectations:

- Assessment and therapeutic care, which will include:
 - Assess within the first 24 hours of admission to evaluate the appropriateness of the client's participation in the program including medical history and current medical stability, current BMI, ability to use appropriate coping skills to live outside the restrictions of a 24-hour setting.
 - Assessing the presenting problem and identifying admission precipitants as well as barriers to returning to routine outpatient care as well as evaluation for co-occurring disorders and their potential impact on the patient's treatment.
 - Development of an individualized treatment plan within 24 hours of services to include a dietary plan, necessary dietary and vitamin supplements, nutritional counseling.
 - A series of structured individual, group, and family therapy (with consent for adults) sessions.
 - Parental/family involvement in psychosocial interventions.
 - Coping skills training closely related to the presenting problems (e.g., recognition of triggers, stress management, symptom management, relapse prevention, crisis planning, etc.).
 - Psychiatric evaluation/monitoring and medical monitoring throughout the program.
 - Psychotropic medication management if indicated.
 - Family education closely related to the presenting problems, such as diagnosis, symptoms, medication, coping skills, etc.
 - Patient education closely related to the presenting problems, such as diagnosis, symptoms, medication, etc.
 - Assessment for any social service needs.
 - School conferencing/coordination (if patient is child/adolescent).
- Discharge planning that begins at admission, which will include:
 - Recommendations and planning for the next level of care
 - Preparation of the patient for the transition to the next level of care ensuring the patient understands diagnosis/symptoms, dietary plan, warning signs of relapse, treatment and community resources.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Planning for ongoing substance abuse screenings or services if appropriate.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and relapse warning signs.
 - Assessment of patient's ability to participate in usual school, work, and other activities.
 - Aftercare planning with a multidisciplinary team, patient and patient supports an arrangement of follow-up appointments at lower level of care such as IOP, psychiatric medication management appointments, and/or other social services or community resources as indicated.
 - Medications (psychotropic and physical health medications) or prescriptions in sufficient quantity to last until scheduled aftercare medication management provider.
 - Vitamin and mineral supplements or liquid feeding supplements as needed.
 - Referrals to appropriate self-help or support group.
 - Plan for monitoring meals and weight as well as dangerous thoughts and behaviors.

- A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Eating Disorders Residential Treatment

Description:

Eating Disorder Residential Treatment is a 24/7 program of psychiatric treatment, supervision and monitoring. Residential Eating Disorder treatment programs may occur in a facility either as a programmatically and physically- distinct unit that is licensed for the specific purpose or as a stand-alone mental health facility. Residential treatment center units and sleeping areas are generally not locked units, although in response to the clinical or medical needs of a particular patient, they may at times be locked when necessary.

Residential treatment programs for patients with Eating Disorder diagnoses will adhere to all standards and regulations set forth by their licensing and accreditation entities. Residential programs for patients with Eating Disorder diagnoses will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and RTC treatment records should comply with those standards as well the Program Expectations outlined in the following:

Program Expectations:

- Within 72 hours prior to admission, there has been a face-to-face assessment with the individual and family/significant others by a licensed behavioral health professional with training and experience consistent with the age and problems of the individual. This assessment includes a clinically-based recommendation for the need for this level of care.
- Staff consists of a multidisciplinary treatment team under the direction of a board-certified/board-eligible psychiatrist with training and experience in the assessment and treatment of eating disorders who performs a face-to-face evaluation with each patient during the first 72 hours following admission and sees him or her as frequently as clinically indicated during the entire stay and, at the least, weekly.
- The patient's mental and physical health needs are provided by the residential program.
- A psychiatrist is available at all times, 24/7 and, a nurse is always on site to assess and treat medical and psychiatric issues, to administer medications as clinically indicated and to assist with crisis intervention.
- The admissions process should include:
 - The documented rationale for a current diagnosis of one of the following: Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and evidence of significant distress/impairment.
 - Within 24 hours of admission, an evaluation by a board-certified/board-eligible psychiatrist with training and experience in the assessment and treatment of eating disorders who also recommends this level of care as appropriate for the patient and considers of the alternative of less restrictive levels of care. Patients are also seen by a psychiatrist with training and experience in treating eating disorders as frequently as clinically indicated throughout the duration of the residential stay and, at the least, weekly.
 - Within the first 24 hours of admission, a physical exam and medical assessment, unless a physician determines that a physical examination within the week prior to admission will suffice.
 - Identification of family and/or significant others for participation in the patient's treatment and needed community resources, unless it would not be in compliance with existing federal or state laws or is clinically contraindicated.
- It is optimal that residential treatment occurs as close to the home and community to which the individual will be discharged. If it is not possible to place the patient close to home/community, consistent family involvement with the individual, regular family therapy sessions, and discharge planning sessions are essential, unless such involvement is clinically contraindicated.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.

- Treatment will include evidence based psychosocial therapies appropriate for diagnosis to include individual therapy at least once weekly, or more frequently as clinically indicated, as well as group therapy at least five times a week. Individualized progress notes will be documented for all individual and group therapeutic encounters, to include notes to explain absences or lack of participation.
- Residential treatment will have a program schedule that includes daily interventions and activities related to treatment goals. Daily individualized progress notes by residential unit staff will document the patient's level of participation in treatment programming, compliance with recommendations/instructions, and behavior in the unit milieu.
- The facility has the ability to quickly assess and address any urgent behavioral and/or medical concerns.
- The involvement of the patient and family/significant others in a timely, consistent basis is very important and expected at each phase of treatment planning, unless it would not be in compliance with existing state/federal laws or would be clinically contraindicated. Patient and family involvement is integral for in the following contexts and, especially important for patients under age 18:
 - Assessment providing detailed initial history to describe and explain the precipitating events, current and past, leading up to the admission.
 - Face-to-face Family Therapy to occur at least weekly, unless clinically contraindicated.
 - Telephone contact for family therapy is acceptable, if the family lives more than three hours from the facility, and must be conducted at least weekly along with face-to-face family sessions occurring monthly.
 - Telephonic sessions are not to be considered as an equal substitute for face-to-face sessions or to be based on the convenience of the provider or family, or for the patient's comfort.
 - Discharge planning.
- For patients under age 18, the developmental, emotional, physical, and educational needs are provided by the residential program throughout the patient's stay, including intensive mental health care, physical health care and on-going education at the patient's appropriate developmental level.
- Residential treatment is not to be used as an alternative for lack of available supportive housing environment(s) for an individual in the community.
- Within 72 hours of admission, a Comprehensive Treatment Plan is to be created for the patient that includes:
 - A central focus on the symptoms and the issues leading to the admission for improvement toward allowing treatment to continue at a less restrictive level of care.
 - Multidisciplinary evaluations of issues related to behavior, medical condition(s), substance misuse, personality traits, social support system, educational needs, and the living environment.
 - The consideration of possible relevant co-morbid conditions is to be part of all psychiatric and medical evaluations.
 - Face-to-face weekly therapy sessions with family/significant others or, if the family/significant others live(s) greater than three hours from the treatment facility, weekly telephone contact for family therapy is to be conducted and documented to include notes to explain the patient's or the family's absences or lack of participation.
 - Specific, measurable, realistic and achievable goals.
 - The comprehensive treatment plan is to:
 - Be jointly created with the patient and the family/significant others.
 - Include multidisciplinary evaluations and recommendations.
 - Include treatment interventions to appropriately address the clinical needs of the patient.
 - Treatment plans and discharge plans for patients with a history of multiple relapses, readmissions and treatment episodes need to have specific interventions to identify and address the rationales for previous non-adherence/poor responses and specific actions to reduce the same risks for the future.

Note: The Treatment Plan is not based on a pre-established programmed plan or timeframes.

- Discharge planning will begin at the point of admission with the expectation that a first appointment for aftercare with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from residential setting. Discharge planning will include:
 - Recommendations and planning for the patient's next level of care.
 - Communication and coordination, prior to discharge, with resources in the community to promote and aid a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports. Confirmation the patient was provided with written instruction for what to do in the event a behavioral health crisis arises before the first aftercare appointment.
 - Assessment of patient's ability to participate in usual work and/or other activities.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until the first scheduled aftercare medication management appointment.
 - A comprehensive discharge summary completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's responses to treatment, patient's condition at the time of discharge, all scheduled aftercare appointments and recommendations, and signature of the person preparing the summary.

Electroconvulsive Therapy (ECT) - Inpatient

Definition:

Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, triggering brief seizures. ECT can be effective in quickly reversing symptoms of certain mental illnesses. ECT is most often used to treat severe depression when medications have been ineffective or not well-tolerated. ECT can be used to treat other psychiatric disorders and conditions, especially when there is need for quickly stabilizing severe psychotic symptoms, acute risk of harm to self or others, catatonia, and/or extreme manic or depressive episodes.

ECT is to be administered in an inpatient setting if the patient requires the 24-hour medical/nursing monitoring or procedures provided in an inpatient level of care or if he or she does not have a suitable environment and support system for recovery and monitoring after ECT administration.

ECT providers will adhere to all standards and regulations set by their licensing and accreditation entities. ECT providers will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and enhanced supported housing treatment records will comply with those standards as well as the following service expectations.

Program Expectations:

- A psychiatric evaluation will be completed prior to administration of ECT that includes:
 - Establishment of diagnostic criteria for a condition is likely to respond to ECT.
 - Psychiatric history including the response to any previous use of ECT, as well as history of other forms of treatment and their outcomes.
 - Current psychiatric symptoms including duration and severity, current mental status, and current functioning.
- A medical assessment will be completed prior to administration of ECT that includes:
 - Identification of all comorbid conditions to rule out any medical problems that would increase the risks of ECT and/or anesthesia.
 - An assessment of currently prescribed medications to identify medications that could negatively impact the procedure, and documentation of the clinical rationale to continue any of these medications if applicable.
 - Documented anesthetic evaluation performed by a qualified anesthesiology professional.
- Evaluation for ECT and administration of ECT will be done by a psychiatrist who meets all regulatory/certification requirements to administer ECT.
- A treatment plan signed by the physician and patient or guardian, with the following elements:
 - Tentative plan for frequency and duration of treatments.
 - Plan for recovery from each treatment.
 - Reassess treatment plan at least weekly or four to five sessions (whichever comes first) that address treatment effectiveness and any treatment plan changes that need to be made.
- Document physiological monitoring during ECT treatment that addresses seizure activity, vital signs, any adverse effects, and any other monitoring specific to the needs of the patient.
- Documented post-ECT stabilization, monitoring and observation that ensure the patient is stable and appropriate to remain at their current level of care.
- The patient and/or guardian and caregiver education to include:
 - Risks/benefits of ECT.
 - Potential side effects and risk factors.
 - Signed informed consent by the patient or legal guardian, with understanding that consent can be withdrawn at any time.
- When the patient is discharged from inpatient level of care, a signed discharge summary is completed to include:
 - Plan for continued outpatient ECT if applicable, including date/time of next appointment.
 - Disposition at the time of discharge, including a summary of course of treatment and progress or lack of progress made.
 - Recommendations for ongoing medical and/or behavioral health services.
 - Scheduled appointments for recommended follow-up behavioral health and/or medical services.

Electroconvulsive Therapy (ECT) - Outpatient

Definition:

Electroconvulsive therapy (ECT) is a procedure, done under general anesthesia, in which small electric currents are passed through the brain, triggering brief seizures. ECT can be effective in quickly reversing symptoms of certain mental illnesses. ECT is most often used to treat severe depression when medications have been ineffective or not well-tolerated. ECT can be used to treat other psychiatric disorders and conditions, especially when there is need for quickly stabilizing severe psychotic symptoms, acute risk of harm to self or others, catatonia, and/or extreme manic or depressive episodes.

ECT can be administered as an outpatient service when the individual is medically stable, not requiring 24 hour medical/nursing monitoring, and has access to a suitable environment and support system after recovery from procedure. ECT Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. ECT programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and ECT treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- A psychiatric evaluation will be completed prior to administration of ECT that includes:
 - Establishment of diagnostic criteria for a condition is likely to respond to ECT.
 - Psychiatric history including the response to any previous use of ECT, as well as history of other forms of treatment and their outcomes.
 - Current psychiatric symptoms including duration and severity, mental status and functioning.
- A medical assessment will be completed prior to administration of ECT that includes:
 - Identification of comorbid conditions to rule out any medical problems that would increase the risks of ECT and/or anesthesia.
 - An assessment of currently prescribed medications to identify medications that could negatively impact the procedure, and documentation of the clinical rationale for continuation of any of these medications if applicable.
 - Documented anesthetic evaluation performed by a qualified anesthesiology professional.
- Evaluation for ECT and administration of ECT will be done by a psychiatrist who meets all regulatory/certification requirements to administer ECT.
- A treatment plan signed by the provider and patient or guardian, with the following documented elements:
 - Tentative plan for frequency and duration of treatments.
 - Plan for recovery from each treatment.
 - Reassess the treatment plan at least weekly or four to five sessions (whichever comes first) that address treatment effectiveness and treatment plan changes that need to be made.
- Documented physiological monitoring during ECT treatment that addresses seizure activity, vital signs, any adverse effects and other monitoring specific to the needs of the patient.
- Documented post-ECT stabilization, monitoring and observation that the patient is stable and appropriate to remain at the current level of care.
- Patient and/or guardian and caregiver education to include:
 - Risks/benefits of ECT.
 - Potential side effects and risk factors.
 - Signed informed consent by the patient or legal guardian, with understanding that consent can be withdrawn at any time.
- The patient will be released in the care of someone able to monitor him/her and provide supportive care. The caregiver will be given written post-procedure instructions that address risk factors and when to seek medical attention for adverse effects.
- Coordinate care with the patient's referring provider, other outpatient behavioral health providers, and/or a primary care provider regarding treatment and treatment outcomes.
- When ECT is discontinued for any reason (completion, patient refusal, medical concerns, etc.), a discharge summary must be completed and signed by the patient/guardian that includes:
 - Disposition at the time of discharge, including a summary of course of treatment and progress or lack of progress made.
 - Recommendations for ongoing medical and/or behavioral health services.
 - Scheduled appointments for recommended follow-up behavioral health and/or medical services.

Neuropsychological Testing

Definition:

Neuropsychological testing involves the assessment of cognitive and/or behavioral impairments due to medical, neurologic, or psychiatric conditions using reliable and valid instruments. This form of testing is considered an adjunctive assessment when differentiation of organic and functional disorders is necessary. It aids in identifying specific therapy needs, determining proper diagnosis, helping establish the degree of impairment, helping to identify the specific anatomic location of the disease, and tracking recovery or response to treatment. Common domains examined include: attention, memory, language, intellectual functioning, visuospatial ability, and executive functioning. The tests and procedures employed should vary as a function of the purpose of the evaluation, and the age and capability of the patient.

Neuropsychological testing is indicated when a patient has a suspected or known diagnosis that is neurological or has a diagnosed infection that is associated with cognitive impairment.

Testing for educational or occupational purposes is not a covered benefit, and should be conducted within the appropriate institution. Repeat testing is permitted when the patient appears to have undergone a significant status change and/or this testing will impact treatment planning.

Report writing and informing cannot be billed as neuropsychological testing.

The compromised cognitive functioning of individuals with substance use disorders often confounds the results of neuropsychological testing in the context of early treatment for substance dependence. Therefore, individuals in a substance abuse treatment setting should not be actively using, in withdrawal, or in recovery from recent substance abuse. It is recommended that there be a minimum of 30 days abstinence prior to the administration of testing for a mood disorder, and a minimum of 90 days abstinence for the assessment of cognitive functioning/impairment.

Providers of neuropsychological testing will adhere to all standards and regulations set forth by their licensing entities. Providers will also adhere to all contractual guidelines, including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records will comply with those standards as well the expectations outlined in the following:

Expectations for Neuropsychological Testing:

- Testing is to be conducted by a mental health professional that is licensed to perform proposed tests. Upon request, this individual must be able to demonstrate they have undergone adequate training and/or supervision to perform the assessments.
- When utilizing a technician, the fully licensed and Psychologist (contracted for neuropsychology) or Neuropsychologist will conduct the clinical interview, design the test battery, interpret the testing results, and sign the report.
- A technician is a licensed certified psychological assistant or licensed psychological examiner.
- Evaluation will include relevant history with regard to medical, behavioral, educational, substance use, and social functioning.
- Selected test instruments will specifically address the referral question(s).
- Test instruments used will be reliable and valid.
- Neuropsychological testing results for outpatient cases should be reported within one week, and within 24 hours (at least informally) for cases involving higher levels of care.
- A complete psychological testing report will be completed to include:
 - Referral question(s)
 - Referral source
 - Background information
 - Assessment procedures
 - Assessment results (including cooperation and motivation of the patient and validity of responses)
 - Interpretation of results
 - Diagnostic impression (current DSM)
 - Summary and recommendations that include plans for further services or referrals to other service providers

Program for Assertive Community Treatment (PACT/ACT)

Definition:

PACT/ACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness (SPMI). These services are appropriate for SPMI adults with a history of difficulties accessing or responding to traditional mental health services or difficulties living successfully in their community. An interdisciplinary team (including case managers, registered nurse, psychiatrist, and other mental health professionals) ensures service availability 24 hours a day, seven days per week and is equipped to provide a full range of treatment functions in a variety of community settings whenever they are needed. An ACT team has small staff to service recipient ratios (approximately 1:10). These treatment teams provide individualized services that enable the individual to better manage the symptoms of their severe mental illness, promote and maintain the highest possible level of functioning in the community, and assist the individual in reaching recovery goals.

PACT/ACT programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. PACT/ACT programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and PACT/ACT treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Thorough assessment of needs and development of an individualized treatment plan to include the entire ACT Team.
- Psychiatric evaluation, medication management, and other medication support as indicated.
- Coordination of care with all relevant behavioral health, medical, and community providers and caregivers.
- Consultation, assessment, and the provision of other needed services including, but not limited to, housing, work opportunities, money management, financial assistance programs, medical/wellness management, substance abuse treatment, and social/family supports.
- Patient and family education regarding diagnoses, treatment and recovery.
- Crisis planning to include the availability of the ACT team 24/7, family and other natural supports, as well as emergency services with evidence of the patient and/or caregiver input and understanding.
- Discharge planning that begins at admission will include:
 - Housing
 - Preparation of patient and supports for transition to next level of care
 - Follow-up appointments
 - Referrals for community assistance and support
 - Medication and supplies
 - Ongoing crisis plan
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Acute Inpatient Hospitalization - Adult

Definition:

Acute Inpatient Psychiatric Hospitalization provides the highest level of psychiatric care. Treatment is provided continuously in a 24-hour secure and protected, medically staffed environment with a multimodal approach. Daily psychiatric evaluations, 24-hour skilled psychiatric nursing care, medical evaluation, and structured milieu are required. This includes administration and continuous monitoring of psychiatric medication.

The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition. An individual may pose an imminent danger to himself/herself or others, be grossly impaired, and/or behavioral or medical care needs are unmanageable at any available lower level of care.

Acute Inpatient Psychiatric Hospitals will adhere to all standards and regulations set forth by their licensing and accreditation entities. Acute Inpatient Psychiatric Hospitals will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Acute Inpatient Psychiatric treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- A psychiatric evaluation completed by a board-eligible/ board-certified psychiatrist or MD in consultation with a psychiatrist within 24 hours of admission.
- Comprehensive care daily by a multidisciplinary team that works under the direction of a board-eligible/board-certified psychiatrist.
- Psychiatric follow-up occurs daily or more frequently as needed by a psychiatrist or licensed prescriber in consultation with a psychiatrist.
- A medical evaluation is completed within 48 hours of admission with medical follow-up as needed or appropriate.
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions including assessment of substance use disorders.
- Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
- To ensure patient safety, the facility will quickly assess and address any urgent behavioral and/or physical issues by assigning observation levels to patients for staff supervision on an ongoing basis as appropriate according to patient needs.
- Monitoring of daily medical functioning including vital signs, clinical assessments, and lab work as needed.

- An Individualized treatment plan is completed within 24 hours of admission and developed according to treatment record standards established in the related Provider Administration Manual.
- Family involvement at every level of treatment including treatment plan development, assessment, therapy and discharge planning. If no family involvement, documentation in the records will indicate patient's refusal throughout inpatient stay.
- Coordination of care/communication with community treatment providers and relevant community resource is an essential part of treatment and discharge planning.
- Discharge planning that begins at admission and includes:
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of appropriate care.
 - Safety/crisis planning with involvement of family/other supports, as indicated.
 - Recommendations and planning for the next level of care.
 - Timely and clinically appropriate aftercare appointments scheduled to take place within seven days of discharge date.
 - Prescriptions for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
 - Referrals for community assistance and supports.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Acute Inpatient Hospitalization - Child/Adolescent

Definition:

Acute Inpatient Psychiatric Hospitalization for children and adolescents provides the highest level of psychiatric care for individuals under age 18. Treatment is provided continuously in a 24-hour secure and protected medically staffed environment with a multimodal approach. Daily psychiatric evaluations, 24-hour skilled psychiatric nursing care, a structured milieu, and access to 24-hour medical services are required. This includes continuous administration and monitoring of psychiatric medication.

The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition. An individual may pose an imminent danger to self or others; be grossly impaired; and/or behavioral or medical care needs are unmanageable at any available lower level of care.

Acute Inpatient Psychiatric Hospitals will adhere to all standards and regulations set forth by their licensing and accreditation entities. Acute Inpatient Psychiatric Hospitals will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers are in the Provider Administration Manual, and Acute Inpatient Psychiatric treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- A psychiatric evaluation completed by a board-eligible/ board-certified psychiatrist or MD in consultation with a psychiatrist within 24 hours of admission.
- Within 72 hours of admission, a face-to-face assessment that includes the child/adolescent and the family will be completed by a licensed behavioral health professional, with training and experience consistent with the age and problems of children and adolescents.
- Comprehensive care daily by a multidisciplinary team that works under the direction of a board-eligible/board-certified psychiatrist.
- Psychiatric follow-up occurs daily or more frequently as needed by a psychiatrist or licensed prescriber in consultation with a psychiatrist.
- A medical evaluation is completed within 48 hours of admission with medical follow-up as needed or appropriate.
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions including assessment of substance use disorders.
- Within 48 hours of admission, there is outreach with existing providers and family members, to obtain needed history and other clinical information.
- To ensure patient safety, the facility will quickly assess and address any urgent behavioral and/or physical issues by assigning observation levels to patients for staff supervision on an ongoing basis as appropriate according to patient needs.

- An Individualized treatment plan is completed within 24 hours of admission and is developed according to treatment record standards established in the related Provider Administration Manual.
- Family involvement including assessment/history leading up to admission, family therapy, treatment planning and discharge planning. If the patient is age 16 or older and there is no family involvement, documentation in the records will indicate his or her refusal of family involvement throughout the inpatient stay.
- Link and/or coordinate with community treatment providers, employers, or any involved legal authorities important to treatment and discharge planning.
- Discharge planning that begins at admission and includes:
 - Coordinate with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of appropriate care.
 - Safety/crisis planning with involvement of family/other supports, as indicated.
 - Timely and clinically appropriate aftercare appointments within seven days of discharge date.
 - Prescriptions for any medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Consultation

Definition:

A psychiatric consultation is an evaluation completed by a psychiatrist at the request of another attending physician in a non-psychiatric treatment setting. Psychiatric consults often occur in an inpatient medical hospital. An attending physician may request a psychiatric consultation for many reasons including, but not limited to: evaluation of a patient exhibiting psychiatric symptoms, evaluation of a patient expressing suicidal or homicidal ideation or a wish to die, evaluation of a patient who requests psychiatric care, evaluation of a patient with known or suspected substance abuse, evaluation of a patient where there is question regarding their capacity to consent to or refuse medical care, or any other concerns about a patient's mental health.

The purpose of the consultation may be to improve patient safety and stability in the medical environment, formulate or rule out potential psychiatric diagnoses, recommend other services that may be needed to immediately address psychiatric problems, and/or make recommendations to patient's treatment plan to address or further evaluate psychiatric issues.

Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Psychiatric Consult treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Expectations for Psychiatric Consultation:

- A psychiatric consultation includes the following documented elements:
 - Reason for requesting consult/goal of psychiatric consultation
 - Psychiatric history to include prior diagnoses, treatments, and outcomes
 - Review of past and current medications
 - Assessment of current symptoms and functioning
 - Mental status exam
 - Brief trauma history
 - Substance abuse history and current assessment of substance use
 - Collateral information when available
 - DSM 5 diagnosis and clinical impressions
 - Recommendations for further testing or evaluation
 - Recommendations for care in the current medical setting
 - Recommendation for services that may not be available in current treatment setting or services that may need to be initiated when patient is medically stable

Psychiatric Intensive Outpatient Program - Adult

Definition:

Intensive Outpatient Programs (IOPs) deliver structured, time-limited, multi-disciplinary mental health treatment to individuals who can be safely treated in an outpatient setting. IOP services may be hospital-based or provided at free-standing facilities. These programs provide a minimum of at least three hours per day of treatment, two to five days per week. IOPs primarily use a group format and are intended for individuals who require multi-modal treatment that cannot be provided in a traditional outpatient setting. The range of services may include group, individual, and family psychotherapy, as well as psychoeducational activities.

The program may function as a step-down program from higher levels of care such as inpatient hospitalization, residential services, and partial hospitalization.

Behavioral Health Intensive Outpatient Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Behavioral Health Intensive Outpatient Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Behavioral Health Intensive Outpatient Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Program must be under the supervision of a licensed clinician and/or psychiatrist.
- Patients in the program must be able to safely control their behavior and not be at risk for harming self or others.
- An assessment of clinical need by a licensed clinician has been completed within seven days before admission including an assessment of psychiatric issues, substance use disorders, medical co-morbidities and other psychosocial factors.
- Program is multi-disciplinary and staffed by mental health professionals with training in the treatment of individuals with mental illness.
- Individualized treatment plan, including pre-discharge planning, is completed within three days of admission into the program and updated at least every eight IOP sessions or more frequently as needed.
- Individualized crisis plan with evidence of the patient and/or caregiver input and understanding.
- Multi-modal treatment is provided which may include individual, family and group therapies.
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/others supports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments and signature of the person preparing the summary.

Psychiatric Intensive Outpatient Program - Child/Adolescent

Definition:

Intensive Outpatient Programs (IOP) for children and adolescents deliver structured, time-limited, multi-disciplinary mental health treatment to individuals who can be safely treated in an outpatient setting. IOP services may be hospital-based or provided at free-standing facilities. These programs provide a minimum of at least three hours per day of treatment, two to five days per week. IOPs primarily use a group format and are intended for individuals who require multi-modal treatment that cannot be provided in a traditional outpatient setting. The range of services may include group, individual, and family psychotherapy, as well as psychoeducational activities. The program may function as a stepdown program from higher levels of care such as inpatient hospitalization, residential services, and partial hospitalization.

Psychiatric Intensive Outpatient Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Psychiatric Intensive Outpatient Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Psychiatric Intensive Outpatient Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Program must be under the supervision of a licensed clinician and/or psychiatrist.
- Children/adolescents in the program must be able to safely control their behavior and are not at imminent risk for harming self or others.
- An assessment of clinical need is completed that includes both the child/ adolescent and parents/family within seven days before admission by a licensed clinician with training and experience related to the treatment of children and adolescents and includes an assessment of psychiatric issues, substance use disorders, medical co-morbidities and other psychosocial factors.
- Program is multi-disciplinary and staffed by mental health professionals with training in the treatment of children and adolescents with mental illness.
- Individualized treatment plan, including pre-discharge planning, is completed within three days of admission into the program and updated at least every eight IOP sessions or more frequently as needed.
- Individualized crisis plan with evidence of the patient's and/or caregiver's input and understanding.
- Multi-modal treatment is provided which may include individual, family and group therapies.
- The initial assessment, the treatment planning process and the entire course of treatment will include family involvement. Family therapy (face- to-face) is vital to treatment and is expected unless it is contraindicated.
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Outpatient Services - Adult

Definition:

Outpatient services are mental health and substance use disorder services provided in an ambulatory care setting. This would include settings such as a mental health centers, substance abuse clinics, a practitioner's office, community health clinics, outpatient departments in hospitals, and also home or school settings (as appropriate). These services are intended to assist individuals with major mental illness, substance abuse disorders, family problems, and a vast array of personal and interpersonal difficulties. Outpatient treatment may include individual therapy, group therapy, family therapy, medication management or any combination of these services. The goals of outpatient behavioral health treatment are personal recovery as well as improving and maintaining the individual's level of functioning.

Psychiatric Outpatient Services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Psychiatric Outpatient Services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Psychiatric Outpatient Services treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- The outpatient level of care is appropriate when the patient is not at imminent risk for harming self or others and is able to control his/ her behavior so that safe and effective treatment can take place.
- A thorough psychosocial assessment by a licensed mental health professional is completed along with a mental status examination.
- The licensed professional's evaluations result in a DSM/ICD diagnosis and treatment recommendations for mental health services including whether a medication evaluation is indicated.
- The treating practitioner and patient will collaborate to establish clearly defined, measurable, and attainable treatment goals as well as strategies to attain these goals.
- The treatment plan is created within the first 30 days of services and adheres to all treatment record standards outlined in the Behavioral Health Care Services section of the related Provider Administration Manual.
- The established treatment plan goals and strategies should guide determinations of the focus, frequency and duration of outpatient visits.
- Coordinate care with other treating providers including the primary care physician (with the patient's signed consent) is maintained.
- Treatment should include family involvement (with the patient's signed consent) unless it is contraindicated.
- Discharge planning begins at admission to the outpatient service with clearly defined treatment plan objectives/criteria which indicate readiness for discharge and includes:
 - Recommendations for community assistance and community supports
 - Safety/crisis planning with involvement of family/othersupports
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse
 - Assessment of ability to participate in usual work or other usual activities

Psychiatric Outpatient Services - Child/Adolescent

Definition:

Outpatient services for children and adolescents are mental health and substance use disorder services provided in an ambulatory care setting. This would include settings such as a mental health centers, substance abuse clinics, and a practitioner's office, community health clinics, outpatient departments in hospitals, and also home or school settings (as appropriate). These services are intended to assist individuals with major mental illness, substance abuse disorders, family problems, and a vast array of personal and interpersonal difficulties. Outpatient treatment may include individual therapy, group therapy, family therapy, medication management, or any combination of these services. The goals of outpatient behavioral health treatment are personal recovery as well as improving and maintaining the individual's level of functioning.

Psychiatric Outpatient Services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Psychiatric Outpatient Services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Psychiatric Outpatient Services treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- The outpatient level of care is appropriate when the patient is not at imminent risk for harming self or others and is able to control his/ her behavior so that safe and effective treatment can take place.
- A thorough psychosocial assessment by a licensed mental health professional is completed along with a mental status examination.
- The licensed professional's evaluations result in a DSM/ICD diagnosis and treatment recommendations for mental health services including whether a medication evaluation is indicated.
- The treating practitioner and patient/guardian will collaborate to establish clearly defined, measurable and attainable treatment goals as well as strategies to attain these goals.
- Treatment plans for patients under age 16 are developed with the involvement of the parent/guardian and include involvement of the parent/guardian at all updates to the treatment plan.
- The treatment plan is created within the first 30 days of services and adheres to all treatment record standards outlined in the Behavioral Health Care Services section of the related Provider Administration Manual.
- The established treatment plan goals and strategies should guide determinations of the focus, frequency and duration of outpatient visits.
- Coordinate care with other treating providers including the primary care physician (with the patient's signed consent) is maintained.
- Treatment should include family involvement (with the patient's signed consent if age 16 or older) unless it is contraindicated.
- Discharge planning that begins at admission to the outpatient service with clearly defined treatment plan objectives/criteria indicating readiness for discharge and includes:
 - Recommendations for community assistance and community supports.
 - Safety/crisis planning with involvement of family/others supports
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse
 - Assessment of ability to participate in usual work, school, or other activities

Psychiatric Partial Hospitalization Program - Adult

Definition:

Psychiatric Partial Hospitalization Programs deliver structured, non-residential and time limited treatment for individuals with acute psychiatric symptoms. These individuals should be able to maintain personal safety within the community. This setting provides treatment similar in intensity and nature to an inpatient hospital setting and includes both nursing and medical interventions. Partial hospitalization programming typically occurs three to seven days a week and between four to six hours per day.

Partial Hospitalization Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. PHP programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and PHP treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment by a licensed clinician within the first 24 hours to identify presenting problems such as, medical conditions, cause of admission and co-morbidities, as well as, any identified barriers for returning to routine outpatient care.
- An individualized treatment plan must be developed within the first 24 hours of treatment.
- A structured program that includes individual, family and group therapy sessions.
- Training on coping skills that are closely related to presenting problems (e.g., symptom management, problem solving, etc.).
- Psychiatric evaluation and monitoring throughout the program by a minimum of one psychiatric visit (MD or nurse practitioner) for every three days of PHP attendance.
- Medication management, if indicated.
- Patient education associated with the presenting problems (e.g., diagnosis, symptoms, medication, risk factors and warning signs of relapse, etc.).
- Family involvement and education with patient consent.
- Assessment for any co-occurring substance abuse disorder.
- Assessment and referral for any identified social service needs.
- Discharge planning begins at admission and includes:
 - Planning and recommendations for the next appropriate level of care.
 - Safety/crisis planning with family involvement and any additional support system.
 - Family and patient education regarding diagnosis, medications, symptoms, signs of relapse and identified risk factors.
 - Assessment of capability to participate in daily activities including work or school.
 - Coordination of follow-up appointments and aftercare planning including, psychotherapy appointments, medication management, medical appointments, and referrals to any other community resources.
 - Provide psychotropic and physical health medications and/or prescriptions in adequate amount until scheduled medication management appointment.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of patient's discharge. The discharge summary should include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Partial Hospitalization Program -Child/Adolescent

Definition:

Psychiatric Partial Hospitalization Programs deliver structured, non-residential and time limited treatment for individuals under age 18 with acute psychiatric symptoms. These individuals should be able to maintain personal safety within the community. This setting provides treatment similar in intensity and nature to an inpatient hospital setting and includes both nursing and medical interventions. Partial hospitalization programming typically occurs three to seven days a week and between four to six hours per day.

Partial Hospitalization Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. PHP programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and PHP treatment records should comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment by a licensed clinician within the first 24 hours to identify presenting problems such as, medical conditions, cause of admission and co-morbidities, as well as, any identified barriers for returning to routine outpatient care.
- An individualized treatment plan must be developed within the first 24 hours of treatment.
- A structured program that includes individual, family and group therapy sessions.
- Training on coping skills that are closely related to presenting problems (e.g., symptom management, problem solving, etc.).
- Psychiatric evaluation and monitoring throughout the program by a minimum of one psychiatric visit (MD or nurse practitioner) for every three days of PHP attendance.
- Medication management, if indicated.
- Patient education associated with the presenting problems (e.g., diagnosis, symptoms, medication, risk factors and warning signs of relapse, etc.).
- Parental/Family involvement in interventions and education.
- Assessment for any co-occurring substance abuse disorder.
- Assessment and referral for any identified social service needs.
- Coordination with school and other entities
- Discharge planning begins at admission and includes:
 - Planning and recommendations for the next appropriate level of care
 - Safety/crisis planning with family involvement and any additional support system
 - Family and patient education regarding diagnosis, medications, symptoms, signs of relapse and identified risk factors
 - Assessment of capability to participate in daily activities including work or school
 - Coordination of follow-up appointments and aftercare planning including, psychotherapy appointments, medication management, medical appointments, and referrals to any other community resources
 - Provide psychotropic and physical health medications and/or prescriptions in adequate amount until scheduled medication management appointment.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of patient's discharge. The discharge summary should include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Residential Treatment - Adult

Definition:

Psychiatric Residential Treatment for Adults is a 24/7 program of psychiatric treatment, supervision and monitoring. Residential treatment programs for adults may occur in a facility either as a programmatically and physically-distinct unit that is licensed for this purpose or as a stand-alone mental health facility. Residential treatment center units and sleeping areas are generally not locked units, although in response to the clinical or medical needs of a particular patient, they may at times be locked when necessary.

Psychiatric Residential Treatment Facilities will adhere to all standards and regulations set forth by their licensing and accreditation entities. Psychiatric Residential Treatment Facilities will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers are in the Provider Administration Manual and Psychiatric Residential treatment records will comply with those standards as well as the Program Expectations below:

Program Expectations:

- Staff consists of a multidisciplinary treatment team under the direction of a board-certified/board-eligible psychiatrist who performs a face-to-face evaluation with each patient during the first 72 hours following admission and sees him or her as frequently as clinically indicated during the entire stay and, at the least, weekly.
- The mental and physical health needs of the patient are provided by the residential program.
- A psychiatrist is available 24/7, and a nurse is always on site to assess and treat medical and psychiatric issues, administer medications as clinically indicated and assist with crisis intervention.
- The focus of treatment is the stabilization and improvement of functioning as well as the reintegration with significant others and/or family.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.
- As a transitional service, the purpose of residential treatment is to return the individual to the community with ongoing outpatient services as needed.
 - At the residential level of care, treatment is not primarily focused on maintaining long-term gains made in earlier programs.
 - The duration of residential treatment is not based on a preset length of stay.
 - The length of stay for some standardized programs (i.e., a “30-Day Treatment Program”) is not considered at this level of care in the review and authorization process as a criterion of medical necessity for admission and/or for concurrent stay.
- Treatment will include evidence based psychosocial therapies appropriate for diagnosis to include individual therapy at least once weekly, or more as clinically indicated, and group therapy at least five times a week. Individualized progress notes will be documented for all individual and group therapeutic encounters and include notes to explain the patient’s absences or lack of participation.
- Residential treatment will have a program schedule that includes daily interventions and activities related to treatment goals. Daily individualized progress notes by residential unit staff will document the patient’s level of participation in treatment programming, compliance with recommendations/instructions and behavior in the unit milieu.
- Within 72 hours of admission, create a Comprehensive Treatment Plan for the patient that includes:
 - A central focus on the symptoms and the issues leading to the admission for improvement toward allowing treatment to continue at a less restrictive level of care.
 - Multidisciplinary evaluations of issues related to behavior, medical condition(s), substance misuse, personality traits, social support system, educational needs, and the living environment.
 - Consideration of possible relevant co-morbid conditions with all psychiatric and medical evaluations.
 - Face-to-face weekly therapy sessions with family/significant others or, if the family/ significant others live(s) greater than three hours from the treatment facility, weekly telephone contact for family therapy is to be conducted with face-to-face family sessions at least monthly and documented to include notes to explain the patient’s or the family’s absences or lack of participation.
 - Specific, measurable, realistic, and achievable goals.
- The comprehensive treatment plan is to:
 - Be jointly created with the patient and the family/significant others.
 - Include multidisciplinary evaluations and recommendations.
 - Include treatment interventions appropriately address the patient’s clinical needs.
- Residential treatment is not to be used as an alternative for lack of available supportive housing environment(s) for an individual in the community.

- Discharge planning will begin at the point of admission with the expectation that a first appointment for aftercare with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from residential setting. Discharge planning will include:
 - Recommendations and planning for the patient's next level of care.
 - Communication and coordination, prior to discharge, with resources in the community to promote and aid a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse
 - Safety/crisis planning with involvement of family and/or other supports. Confirmation that the patient was provided written instruction for what to do in the event that a behavioral health crisis arises prior to the first after-care appointment.
 - Assessment of the patient's ability to participate in usual work and/or other activities.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until the first scheduled aftercare medication management appointment.
 - A comprehensive discharge summary completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's responses to treatment, patient's condition at the time of discharge, all scheduled aftercare appointments and recommendations, and signature of the person preparing the summary.

Psychiatric Residential Treatment - Child/Adolescent

Definition:

Psychiatric Residential Treatment for Children and Adolescents is a 24/7 program of psychiatric treatment, supervision and monitoring. Residential treatment programs for children and adolescents may occur in a facility either as a programmatically and physically-distinct unit that is licensed for this purpose or as a stand-alone mental health facility. Residential treatment center units and sleeping areas are generally not locked units, although, in response to the clinical or medical needs of a particular patient, they may at times be locked when necessary.

Psychiatric Residential Treatment Facilities will adhere to all standards and regulations set forth by their licensing and accreditation entities. Psychiatric Residential Treatment Facilities will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Psychiatric Residential treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- The staff of residential treatment centers for children and adolescents consists of a multidisciplinary treatment team under the direction of a board-certified/ board-eligible psychiatrist who performs a face-to-face evaluation with each patient during the first 72 hours following admission and sees him or her as frequently as clinically indicated during the entire stay and, at the least weekly.
- The child's developmental, emotional, physical, and educational needs are provided by the residential program throughout the patient's stay including intensive mental health care, physical health care, and on- going education at the patient's appropriate developmental level.
- A psychiatrist is available at all times, 24/7, and a nurse is always on site to assess and treat medical and psychiatric issues, administer medications as clinically indicated and assist with crisis intervention.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.
- Within 72 hours of admission, a Comprehensive Treatment Plan is to be created for the patient that includes:
 - A central focus on the symptoms and the issues leading to the admission for improvement toward allowing treatment to continue at a less restrictive level of care.
 - Multidisciplinary evaluations of issues related to behavior, medical condition(s), substance misuse, personality traits, social support system, educational needs, and the living environment.
 - The consideration of possible relevant co-morbid conditions is to be part of all psychiatric and medical evaluations.
 - Face-to-face weekly therapy sessions with family or, if the family lives greater than three hours from the treatment facility, weekly telephone contact for family therapy is to be conducted and documented to include notes to explain the patient's or the family's absences or lack of participation.
 - Specific, measurable, realistic and achievable goals.
 - The comprehensive treatment plan is to:
 - Be jointly created with the patient and the family/significant others.
 - Include multidisciplinary evaluations and recommendations.
 - Include treatment interventions appropriately address the patient's clinical needs.
- The focus of treatment is the stabilization and improvement of functioning as well as the reintegration with significant others and/or family.
- Treatment will include evidence based psychosocial therapies appropriate for diagnosis to include individual therapy at least once weekly, or more frequently as clinically indicated, and group therapy at least five times a week. Individualized progress notes will be documented for all individual and group therapeutic encounters, to include notes to explain the patient's absences or lack of participation.
- Residential treatment will have a program schedule that includes daily interventions and activities related to treatment goals. Daily individualized progress notes by residential unit staff will document the patient's level of participation in treatment programming, compliance with

recommendations/instructions and behavior in the unit milieu.

- As a transitional service, the purpose of residential treatment is to return the individual to the community with ongoing outpatient services as needed.
 - At the residential level of care, treatment is not primarily focused on maintaining long-term gains made in earlier programs.
 - The duration of residential treatment is not based on a preset length of stay.
 - The length of stay for some standardized program (i.e., a “30-Day Treatment Program”) is not considered at this level of care in the review and authorization process as a medically necessary criteria for admission and/or for concurrent stay.
- Residential treatment is not to be used as an alternative for lack of available supportive housing environment(s) for an individual in the community.
- Discharge planning will begin at the point of admission with the expectation that a first appointment for aftercare with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from residential setting. Discharge planning will include:
 - Recommendations and planning for the patient’s next level of care
 - Communication and coordination, prior to discharge, with resources in the community to promote and aid a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient’s diagnosis, symptoms, medications, risk factors and warning signs of relapse
 - Safety/crisis planning with involvement of family and/or other supports. Confirm the patient received written instruction for what to do in the event that a behavioral health crisis arises prior to the first after-care appointment.
 - Assessment of a patient’s ability to participate in usual work and/or other activities.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until the first scheduled aftercare medication management appointment.
 - A comprehensive discharge summary completed and available in treatment record within 10 business days of a patient’s discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient’s responses to treatment, patient’s condition at the time of discharge, all scheduled aftercare appointments and recommendations, and signature of the person preparing the summary.

Psychiatric Sub-Acute Hospitalization - Adult

Definition:

The sub-acute hospitalization level of care is designed to meet the needs of patients with mental health problems that require an inpatient setting due to potential for harm to self or to others due to an inability to adequately care for his/her personal needs without presenting an imminent threat to self or others. The purpose of sub-acute care programs is to provide rehabilitation and recovery services and assist in a patient's return to baseline function and transition back into the community. Sub-acute care programs serve patients who require less-intensive care than acute inpatient hospital care, but more intensive care than residential treatment. Twenty-four hour monitoring and supervision by a multidisciplinary behavioral health treatment team provide a safe and effective treatment environment. Patients in this setting should have adequate impulse control and the ability to cooperate with staff to communicate effectively and accomplish the tasks of daily living with minimal support. Patients are ready for discharge from this level of care when they show good impulse control, medication compliance, effective communication and the ability to accomplish activities of daily living consistent with their developmental capabilities.

Sub-Acute Psychiatric Hospitals will adhere to all standards and regulations set forth by their licensing and accreditation entities. Sub-Acute Psychiatric Hospitals programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Sub-Acute Psychiatric Hospital treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations

- A DSM-5 diagnosis resulting from a face-to-face psychiatric evaluation performed within 24 hours of admission by a board eligible/board-certified psychiatrist or MD in consultation with a psychiatrist
- Staff supervision provided 24 hours per day/seven days per week to develop skills necessary for adaptive/functional behavior that will allow the patient to live outside of a sub-acute hospital setting.
- Intensive psychiatric/medical and nursing care for continuous observation and monitoring available 24 hours a day to include:
 - Family therapy that occurs weekly. The family is to be involved at every level of treatment including assessment, treatment planning, therapy and discharge planning. If no family involvement, documentation in the records will indicate patient refusal.
 - Specific target symptoms are to be identified when using psychotropic medications.
 - Evaluation for current medical problems and co-morbid substance issues.
 - Ongoing medical services to evaluate and manage co-morbid medical conditions and substance abuse issues.
 - Coordination with community resources to facilitate a smooth transition back home, family, work or school.
- Daily psychiatric nursing evaluation and intervention.
- Direct services by a psychiatrist or licensed prescriber in consultation with a psychiatrist (including medication management) at least weekly.
- Psychotherapy and social interventions appropriate for diagnosis in a structured therapeutic setting.
- The facility must be able to quickly assess and address any urgent behavioral and/or physical concerns.
- Coordinate care with all other relevant healthcare providers throughout the course of care and at discharge.
- Drug screenings and other relevant lab work is considered at the time of admission, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction.
- An Individualized Treatment Plan is to be completed within 24 hours of admission and is developed according to treatment record standards established in the related Provider Administration Manual.

- Patient and family/other supports involvement in assessing and discussing barriers to discharge.
- Discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from inpatient setting. Discharge planning will include:
 - Evidence that an individualized discharge plan has been developed which includes realistic, objective and measurable discharge criteria.
 - Discharge plan must be submitted with discharge notification.
 - Recommendations and planning for the next level of care.
 - Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Assess ability to participate in usual work or other activities.
 - Timely and clinically appropriate aftercare appointments.
 - Aftercare planning and arrangement of follow-up appointments at lower level of care and/or other social services or community resources as needed.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until scheduled aftercare medication management.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychiatric Sub-Acute Hospitalization – Child/Adolescent

Definition:

Sub-acute facilities are psychiatric residential treatment facilities (PRTF) that provide psychiatric and other therapeutic and clinically informed services to individuals under age 21 whose immediate treatment needs require a structured 24-hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual/ family/group therapy, parent guidance, substance abuse education/ counseling (as indicated) and other support services including on site education, designed to assist the young person to achieve success in a less restrictive setting. This level of care primarily serves as a step down from acute psychiatric inpatient care and, may, on occasion, be appropriate for children to be admitted directly from the community.

Patients in this setting should have adequate impulse control and the ability to cooperate with staff to communicate effectively and to accomplish the tasks of daily living with minimal support. Patients are ready for discharge from this level of care when they show good impulse control, medication compliance, effective communication and the ability to accomplish activities of daily living consistent with their developmental capabilities.

Sub-Acute Psychiatric Hospitals will adhere to all standards and regulations set forth by their licensing and accreditation entities. Sub-Acute Psychiatric Hospitals programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Sub-Acute Psychiatric Hospital treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations

- A DSM-5 diagnosis resulting from a face-to-face psychiatric evaluation performed within 24 hours of admission by a board eligible/board-certified psychiatrist or MD in consultation with a psychiatrist.
- Supervision by staff provided 24 hours per day/seven days per week to develop skills necessary for adaptive/functional behavior that will allow the patient to live outside of a subacute hospital setting.
- Intensive psychiatric/medical and nursing care for continuous observation and monitoring available 24 hours a day to include:
 - Family therapy that occurs weekly. The family is to be involved at every level of treatment including assessment, treatment planning, therapy and discharge planning. If no family involvement, documentation in the records will indicate patient refusal.
 - Specific target symptoms are to be identified when using psychotropic medications.
 - A medical evaluation is completed within 24 hours of admission.
 - Ongoing medical services to evaluate and manage co-morbid medical conditions.
 - Evaluation for co-morbid substance use issues.
 - Coordination with community resources to facilitate a smooth transition back home, family, work or school.
- Ongoing academic schooling is provided to facilitate a transition back to the child's previous school setting.
- Young children (12 years and younger) will be admitted to a unit exclusively for children.
- Daily psychiatric nursing evaluation and intervention.
- Direct services by a psychiatrist or licensed prescriber in consultation with a psychiatrist (including medication management) at least weekly.
- Psychotherapy and social interventions in a structured therapeutic setting.
- The facility must have the ability to rapidly assess and address any urgent behavioral and/or physical concerns.
- Coordination of care with all other relevant healthcare providers throughout the course of care and at discharge.
- Drug screenings and other relevant lab work is considered at the time of

admission, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction

- Individualized treatment plan is completed within 24 hours of admission. This plan will be developed jointly with the patient and family/other supports.
- Patient and family/other supports involvement in assessing and discussing barriers to discharge.
- Discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from inpatient setting. Discharge planning will include:
 - Evidence that an individualized discharge plan has been developed which includes realistic, objective, and measurable discharge criteria.
 - Discharge plan must be submitted with discharge notification.
 - Recommendations and planning for the next level of care.
 - Coordination with community resources to facilitate a smooth transition back to home, family, school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Assess ability to participate in usual work or other activities.
 - Timely and clinically appropriate aftercare appointments.
 - Aftercare planning and arrangement of follow-up appointments at lower level of care and/ or other social services or community resources as needed.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until scheduled aftercare medication management.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of the patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Psychological Testing

Definition:

Psychological testing is an outpatient service utilizing one or more standardized practices and methodologies to assess analytical/logical and cognitive abilities, psychopathology, interpersonal skills, psychiatric symptomatology, adaptive functions and/or behavioral conduct. Psychological testing is provides ways to formally and accurately measure and differentiate diagnosis/factors in treatment recommendations for psychiatric disorders. The psychological testing instruments are validated and considered adjunctive to various assessment tools. These tools may be a face-to face clinical interview, individual's history, information obtained from gathering and review use of behavioral rating scales, and consultation with collateral sources. Tests and procedures employed vary as a function of the purpose of the evaluation and the age and capability of the patient.

Testing for educational or occupational purposes is not a covered benefit. Psychological testing for educational or occupational purposes will not be included and is to be conducted within the appropriate institute. Repeat testing is permitted when the patient appears to have undergone a significant status change and/or this testing will impact treatment planning. Report writing and informing cannot be billed as psychological testing.

The compromised cognitive functioning of individuals with substance use disorders often confounds the results of psychological testing in the context of early treatment for substance dependence.

Therefore, individuals in a substance abuse treatment setting should not be actively using, in withdrawal, or in recovery from recent substance abuse. It is recommended that there be a minimum of 30 days abstinence prior to the administration of testing for a mood disorder, and a minimum of 90 days abstinence for the assessment of cognitive functioning/impairment.

Providers of psychological testing will adhere to all standards and regulations set forth by their licensing entities. Psychological testing providers will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records will comply with those standards as well the expectations outlined in the following:

Expectations for Psychological Testing:

- Testing is to be conducted by a mental health professional that is licensed to perform proposed tests. Upon request, this individual must be able to demonstrate that they have undergone adequate training and/or supervision to perform the assessments.
- When utilizing a psychological assistant or a psychological examiner for administration of tests, the fully licensed psychologist, senior psychological examiner, or neuropsychologist will conduct the clinical interview, design the test battery, interpret the testing results, and sign the report.
- Evaluation will include relevant history with regard to medical, behavioral, educational, substance use, and social functioning.
- Selected test instruments will specifically address the referral question(s).
- Test instruments used will be reliable and valid.
- Psychological testing results for outpatient cases should be reported within one week, and within 24 hours (at least informally) for cases involving higher levels of care.
- A complete psychological testing report will be completed to include:
 - Referral question(s)
 - Referral source
 - Background information
 - Assessment procedures
 - Assessment results (including the cooperation and motivation of the patient and validity of responses)
 - Interpretation of results
 - Diagnostic impression (current DSM)
 - Summary and recommendations, to include plans for further services or referrals to other service providers

Psychosocial Rehabilitation

Definition:

Psychosocial rehabilitation services use a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individual's functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals with severe and persistent mental illnesses as active and productive members of their communities with the ability to manage their illness and their lives with as little professional intervention as possible. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Psychosocial Rehabilitation Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Psychosocial Rehabilitation programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Psychosocial Rehabilitation treatment records will comply with those standards as well the Program Expectations outlined in the following:

Program Expectations:

- Within 14 days of admission into the program, develop an individualized treatment plan for the patient that includes clear goals/ objectives for recovery and updated at least every six months.
- A Tennessee licensed mental health professional is on staff or available on a consultative basis.
- Core Services are provided in the following areas:
 - Improving the ability of patients to manage and cope with their illness.
 - Entitlement/income budget maintenance.
 - Self-care and independent living skills.
 - Social Skills.
 - Vocational development.
- Depending on the patient's needs/preferences and in addition to core services, the program either provides or makes referrals for:
 - Advocacy Services.
 - Substance Abuse services.
 - Educational services.
 - Family support and education.
 - Job placement and support.
 - Mental health services.
 - Self-help and peer support.
 - Safe and affordable housing.
- Medical services
- Coordination of care is provided with medical and behavioral health providers that are already involved in the patient's treatment.
- Discharge plan is developed when the patient has achieved his/her short and long-term goals or moves outside of the service area and includes coordination with providers who will deliver post-discharge care.

Respite Care – Adult

Definition:

Respite Care is a short-term crisis stabilization response that provides stabilization and safety in a licensed facility or licensed home for a maximum of three calendar days. It provides breaks for caregivers and gives an option to de-escalate a situation while avoiding hospitalization. It is designed to relieve stress and provide a safe environment for the patient while assessing his or her treatment needs. Respite Care can be provided in a variety of settings. The purpose is to stabilize the patient within the three-day period and prepare him/her for reintegration back into the living environment from which he/she came. If the patient cannot return home within three days, he or she will be referred to a clinically-determined level of care. This intervention provides a safe, controlled environment with a high degree of supervision and structure in which the patient receives therapeutic assessment and intervention.

Respite Care Facilities will adhere to all standards and regulations set forth by their licensing and accreditation entities. Respite Care Facilities will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Respite Care records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- An evaluation of the patient's and caregiver's need is performed upon admission if not already performed by mobile crisis services or other appropriate clinician.
- An individualized service plan is developed in conjunction with the patient and/or his or her family/caregiver that includes the following:
 - The Respite goal.
 - Specific, measurable objectives aimed at achieving the goal of Respite.
- The service plan incorporates instructions for medical care, special needs and emergencies.
- The service addresses the need for other care and resources that become apparent during the provision of Respite. As needed, the provider assists the patient access other services and resources.
- The service plan may be informed by the findings of the initial clinical evaluation.
- The provider ensures that necessary medications, medical equipment and assistive technology accompany the patient when Respite is provided at a site other than his or her residence.
- Discharge Planning:
 - Identification of needed internal and external resources and services.
 - Patient, family, guardian and other supports involved in plan development as appropriate.
 - Communication of current information to next level of care providers.
 - Identification of contacts and their responsibilities at next level of care.

Respite Care – Child/Adolescent

Definition:

Respite Care is a short-term crisis stabilization response that provides stabilization and safety in a licensed facility or licensed home for children/youth for a three day initial authorization and up to five days total. It provides the child/youth with an opportunity to stabilize problematic and escalating behaviors. The respite enables the child/youth and family to work intensely with the community providers so that the child/youth and family will be unified within three to five calendar days. The parent/guardian/custodian must agree to take the child/youth back when the crisis behavior is stabilized. If the child/youth is unable to return home within five days, the child/youth will be referred to a clinically-determined level of care or to an alternative living situation. This intervention provides a safe, controlled environment with a high degree of supervision and structure in which the child/youth receives therapeutic intervention and specialized programming. The purpose is to stabilize the child/youth within the five-day period and prepare him/ her for reintegration back into the living environment from which he/she came.

Respite Care Facilities will adhere to all standards and regulations set forth by their licensing and accreditation entities. Respite Care Facilities will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Respite Care records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- An evaluation of the patient's and caregiver's needs is performed upon admission if not already performed by mobile crisis services or other appropriate clinician.
- An individualized service plan is developed in conjunction with the patient and/or his or her family/caregiver that includes the following:
 - The Respite goal.
 - Specific, measurable objectives aimed at achieving the goal of Respite.
- The service plan incorporates instructions for medical care, special needs and emergencies.
- The service addresses the need for other care and resources that become apparent during the provision of Respite. As needed, the provider helps the patient access other services and resources.
- The service plan may be informed by the findings of the initial clinical evaluation.
- The provider ensures that necessary medications, medical equipment and assistive technology accompany the patient when Respite is provided at a site other than his or her residence.
- Discharge Planning:
 - Identify needed internal and external resources and services.
 - Patient, family, guardian and other support involved in plan development as appropriate.
 - Communicate current information to next level of care providers.
 - Identify contacts and their responsibilities at next level of care.

Sexual Offender Intensive Outpatient Program

Definition:

Sexual Offender Services are a comprehensive approach to juvenile treatment (under age 18) who have admitted to, been adjudicated for, or are indicated for sexually abusive behavior. Sexual Offender Intensive Outpatient Programs (IOP) provide coordinated, multi-disciplinary, time limited treatment for patients who require a level of intensity not available in a standard outpatient setting. These programs provide a minimum of at least three hours per day of treatment, two to five days per week. The program may function as a stepdown from Sexual Offender Residential Treatment Center services.

Treatment goals for addressing adolescents with sexually offensive behavior include but are not limited to these - concrete objectives: 1) Understand, identify, and interrupt thoughts, feelings, beliefs and behaviors that contribute to abuse and all unhealthy choices and behaviors; 2) Develop responsibility for personal choices and behavior without minimization or justification; 3) Understand the impact of past trauma on self-image, functioning, difficulties and behaviors; 4) Develop awareness, sensitivity and compassion for others; 5) Learn and understand normative and inappropriate and/or unhealthy sexual development; 6) Identify, interrupt and control unhealthy and/or inappropriate sexual thoughts and impulses; 7) Learn and use adaptive coping and social skills; 8) Build and engage in non-coercive relationships; and 9) Develop and use healthy interventions and life skills to successfully reenter a healthy developmental trajectory.

Sexual Offender IOPs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Treatment providers, at a minimum, have obtained necessary education, training, and supervision to address the assessment and treatment needs of children and adolescents with sexual behavior problems. Treatment providers are only to employ those skills and techniques for which he/she has education, training, and experience. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Sexual Offender RTC treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Program must be under the supervision of a licensed clinician and/or psychiatrist.
- Children/adolescents in the program must be able to safely control their behavior and are not at imminent risk for harming self or others.
- Patient has had a psychosexual assessment that includes:
 - Age appropriate/developmentally appropriate psychosexual testing to include risk of reoffending.
 - Identification of the behaviors that place the patient and others at risk.
 - Diagnosis of comorbid mental health conditions that will impact the level of care needed for the safety of the patient and/or the community.
- Individualized treatment and safety plans are in place at the time of admission that includes the patient's at risk behaviors, identification of successful accomplishment of treatment goals and planning for stepdown to less intensive services. The comprehensive treatment plan will be revised/updated to reflect progress at least every eight IOP sessions.
- Treatment plan takes motivational and behavioral diversity into account, and focuses on family, peer, and other contextual correlates of sexually abusive behavior in youth, rather than focusing on individual psychological deficits alone.
- Facility provides clinical interventions that are consistent with the intended treatment plan outcomes and include individual, family, and group therapies.
- Parental/guardian/caretaker involvement from the beginning of treatment and continuing throughout the treatment. Family sessions will occur with no less than two sessions face to face per month and weekly phone sessions. Family involvement is necessary in developing a safety plan in the home and community that includes appropriate patient supervision.
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/others supports.
 - Patient/family education on patient's diagnosis, symptoms, medicine, risk factors and relapse warning signs.
 - Assessment of ability to participate in usual school and other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within seven days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - Coordination with legal authorities and/or DCS as indicated.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge to include admission date, presenting problem, summary of care, reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments and signature of the person preparing the summary.

Sexual Offender Residential Treatment

Definition:

Residential Sexual Offender Treatment Services are a comprehensive approach to juvenile treatment (under age 18) who have admitted to, been adjudicated for, or are indicated for sexually abusive behavior. Residential Treatment facilities provide 24-hour, seven days per week treatment, supervision, and monitoring in a safe therapeutic environment. Specialized multi-systematic (e.g., individual, family, school, environment) treatment programming is provided in a controlled, highly structured environment and in the context of a treatment plan that is individualized. Concrete objectives found in effective treatment approaches for addressing adolescents with sexually offensive behavior include but are not limited to: 1) Identify, understand, and interrupt the thoughts, feelings, beliefs and behaviors that contribute to abuse as well as any unhealthy behaviors and choices; 2) Develop personal responsibility for choices and behavior with justification or minimization; 3) Understand how past trauma impacts functioning, behaviors, and self-image; 4) Gain awareness and cultivate sensitivity and compassion for others; 5) Distinguish between normative and inappropriate and/or unhealthy sexual development; 6) Identify, interrupt and control unhealthy and/or inappropriate sexual impulses and thoughts; 7) Learn and use adaptive coping skills and social skills; 8) Cultivate and engage in non-coercive relationships; 9) Develop and use interventions and life skills that are healthy and allow successful reentry to a healthy developmental life path; 10) Develop the necessary competency, resiliency and protective factors to successfully resolve and/or eliminate etiological and maintenance factors, as well as achieve the skills and goods required to be healthy and succeed in community settings.

Sexual Offender RTCs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Treatment providers, at a minimum, have obtained necessary education, training, and supervision that address the assessment and treatment needs of children and adolescents with sexual behavior problems. Treatment providers are only to employ those skills and techniques for which he/she has education, training, and experience. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Sexual Offender RTC treatment records will comply with those standards as well the Program Expectations outlined in the following:

Program Expectations:

- A more intensive level of care is not required for the child/ adolescent patient's behavioral and/or psychiatric symptoms.
- An evaluation, within 72 hours of admission, by a board-certified/board-eligible psychiatrist with training and experience in the assessment and treatment of sexualized behaviors who also recommends the appropriateness for this level of care, considers alternative less restrictive levels of care, and who sees the patient as frequently as clinically indicated throughout the duration of the residential stay, but at least once weekly.
- Separate units for latency-age children and adolescents are maintained by the treatment facility and, a safe, positive peer culture is provided.
- A psychiatrist is available 24 hours per day, seven days per week and a nurse is on-site to assist with crisis intervention and to assess/treat medical and psychiatric issues, and to administer medications as indicated clinically.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.
- The patient has had a psychosexual assessment that includes:
 - Developmentally appropriate/age appropriate psychosexual testing which specifically includes risk of reoffending.
 - Identification of specific behaviors that place the patient and others at risk of harm.
 - Diagnosis of comorbid mental health conditions that impact the needed level of care to provide safety for the patient and/or the community.
- Within 72 hours of admission, a Comprehensive Treatment Plan is to be created for the patient that includes:
 - At-risk behaviors.
 - Specific, measurable, realistic and achievable goals.
 - Rather than focusing only on the patient's psychological deficits, consider motivational and behavioral diversity along with contextual correlates of sexualized behavior such as family, peers and other factors.

- Joint creation with the patient and the family/significant others, unless clinically contraindicated.
- Multidisciplinary evaluations and recommendations.
- Treatment interventions that appropriately address the patient's clinical needs.
- Identification of successful achievement of treatment goals.
- Planning for stepdown to less intensive services.
- Treatment will include evidence based psychosocial therapies appropriate for diagnosis to include individual therapy at least once weekly, or more frequently as clinically indicated, and group therapy at least five times a week. Individualized progress notes will be documented for all individual and group therapeutic encounters, to include notes to explain the patient's absences or lack of participation.
- Residential treatment will have a program schedule that includes daily interventions and activities related to treatment goals. Daily individualized progress notes will document the patient's level of participation in treatment programming, compliance with recommendations and behavior in the milieu.
- Parental/guardian involvement from the beginning of treatment and continuing throughout the treatment. Face-to-face weekly therapy sessions with family or, if the family lives greater than three hours from the treatment facility, weekly telephone contact for family therapy is to be conducted and documented to include notes to explain the patient's or the family's absences or lack of participation.
- Residential treatment should not be used as an alternative for lack of available supportive housing environment(s) for an individual in the community.
- Discharge planning will begin at the point of admission with the expectation that a first appointment for aftercare with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from residential setting. Discharge planning will include:
 - Recommendations and planning for the patient's next level of care.
 - Communication and coordination, prior to discharge, with resources in the community to promote and aid a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports. Confirm the patient received written instruction for what to do in the event that a behavioral health crisis arises prior to the first after-care appointment.
 - Assessment of the patient's ability to participate in usual school and/or other activities.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until the first scheduled aftercare medication management appointment.
 - A comprehensive discharge summary completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's responses to treatment, patient's condition at the time of discharge, all scheduled aftercare appointments and recommendations, and signature of the person preparing the summary.

Substance Use Disorders Inpatient Detoxification - Adolescent

Definition:

Acute inpatient detoxification is an inpatient substance abuse treatment program that provides medical detoxification for patients age 13-17, and is used when the following services are needed:

- Intensive psychiatric/medical and nursing care for continuous observation and 24-hour monitoring.
- Availability of appropriate medical professionals, including 24-hour nursing staff for monitoring/care and physician visits at least daily.
- A contained environment for specific detox treatments that cannot be safely done in less acute level of care.
- Daily monitoring of detox symptoms, administration and monitoring of detox medicine, administration and monitoring of psychiatric medication, and monitoring for adverse effects or reactions.

Inpatient Detox programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Inpatient Detox programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Inpatient Detox treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment and therapeutic care, which will include:
 - Pre-admission screening for determination of appropriate level of care.
 - A psychiatric evaluation completed by a board-eligible/ board-certified psychiatrist, addictionologist or an MD in consultation with a psychiatrist, within 24 hours of admission.
 - A medical evaluation completed within 48 hours of admission that considers co-occurring conditions with medical follow-up as needed or appropriate.
 - Within 72 hours of admission, a face-to-face assessment that includes both the child/adolescent and the family will be completed by a licensed behavioral health professional, with training and experience consistent with the age and problems of children and adolescents.
 - Comprehensive follow-up care for clinical management of all medications occurs daily or more frequently as needed by a psychiatrist or licensed prescriber in consultation with a psychiatrist.
 - Outreach, within 48 hours of admission to existing providers and family members to obtain needed history and other clinical information.
 - The ability of the facility to quickly assess and address any urgent behavioral and/or physical issues.
 - Linkage and/or coordination with community treatment providers, employers, or any involved legal authorities important to treatment and discharge planning.
 - An Individualized Treatment Plan is to be completed within 24 hours of admission and is developed according to treatment record standards established in the related Provider Administration Manual.
 - For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous poor response/non-adherence and clear interventions for the reduction of future risks.
 - Treatment will include evidence-based psychosocial therapies appropriate for diagnosis.
 - Coordination of care with obstetrical provider for pregnant adolescents, as well as provision for pregnant adolescents to receive all recommended obstetrical care while in detox level of care.
 - Family involvement at every level of treatment including assessment, treatment planning, therapy and discharge planning. If no involvement, documentation in the records will indicate patient's refusal throughout inpatient stay.
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Patient/family education on patient's diagnosis, symptoms, medicine, risk factors and relapse signs.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and follow-up appointment scheduling at lower level of care, psychiatric medication management appointments, psychotherapy appointments, medical appointments, and/or other social services or community resources as indicated. Appointments should happen no later than seven days after discharge. Direct transfer to lower levels of care is preferable if possible.
 - Medications (psychotropic and physical health medications) or prescriptions in sufficient quantity to last until scheduled aftercare medication management provider.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of the patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Inpatient Detoxification - Adult

Definition:

Acute inpatient detoxification is an inpatient substance abuse treatment program that provides medical detoxification and is used when the following services are needed:

- Intensive psychiatric/medical and nursing care for continuous observation and 24-hour monitoring.
- Availability of appropriate medical professionals, including 24-hour nursing staff for monitoring/care and physician visits at least daily.
- A contained environment for specific detox treatments that could not be safely done in a less acute level of care.
- Daily monitoring of detox symptoms, administration and monitoring of detox medications, administration and monitoring of psychiatric medication, and adverse effect/reaction monitoring.

Inpatient Detox programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Inpatient detox programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Inpatient Detox treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment and therapeutic care, which will include:
 - Psychiatric evaluation completed by a board-eligible/board-certified psychiatrist, addictionologist or an MD in consultation with a psychiatrist, within 24 hours of admission.
 - Medical evaluation done within 48 hours of admission and medical follow-up as needed/appropriate.
 - Comprehensive follow-up care for clinical management of all medications occurs daily or more frequently as needed by a psychiatrist or licensed prescriber in consultation with a psychiatrist.
 - Outreach, within 48 hours of admission, to existing providers and family members, to obtain needed history and other clinical information.
 - Facility's ability to quickly assess and address any urgent behavioral and/or physical issues.
 - Linkage and/or coordination with community treatment providers, employers, or any involved legal authorities important to treatment and discharge planning.
 - An Individualized Treatment Plan completed within 24 hours of admission and developed according to treatment record standards established in the Provider Administration Manual.
 - For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous poor response/non-adherence and clear interventions for the reduction of future risks.
 - Treatment will include evidence-based psychosocial therapies appropriate for diagnosis.
 - Coordination of care with obstetrical provider for pregnant women, as well as provision for pregnant women to receive all recommended obstetrical care while in detox level of care.
 - Family involvement at every level of treatment including assessment, treatment planning, therapy and discharge planning. If no family involvement, documentation in the records will indicate patient's refusal throughout inpatient stay.
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and relapse warning signs.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and arrangement of follow-up appointments at next lower level of care, psychiatric medication management appointments, psychotherapy appointments, medical appointments, and/or other social services or community resources as indicated. Appointments should be arranged no later than seven days after discharge. Direct transfer to lower levels of care is preferable when possible.
 - Medications (psychotropic and physical health medications) or prescriptions in sufficient quantity to last until scheduled aftercare medication management provider.
 - Referrals for community assistance and supports as needed.
 - A comprehensive discharge summary completed and in treatment record within 10 business days of the patient's discharge to include admission date, presenting problem, care summary, reason for discharge, patient's condition at discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Inpatient Hospitalization - Adolescent

Definition:

Acute inpatient substance use disorders treatment for individuals under the age of 18 provides intensive psychiatric, medical, and nursing care/monitoring 24 hours a day, seven days a week in an inpatient setting for those without the need for acute detoxification treatment but cannot be safely maintained in a substance abuse residential treatment setting. Treatment is provided by a multidisciplinary team in an acute setting to closely monitor behavioral, medical, psychiatric or potential detox symptoms until the patient can safely be treated at a lower level of care.

Substance Use Disorder Inpatient Programs adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorder Inpatient programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers are in the Provider Administration Manual, and Substance Use Disorder Inpatient treatment records will comply with those standards as well as the Program Expectations outlined below:

Program Expectations:

- A psychiatric evaluation completed by a psychiatrist or addictionologist within 24 hours of admission.
- Within 72 hours of admission, a face-to-face assessment that includes both the child/adolescent and the family will be completed by a licensed behavioral health professional, with training and experience consistent with the age and problems of children and adolescents.
- An Individualized Treatment Plan is to be completed within 24 hours of admission and is developed according to treatment record standards established in the related Provider Administration Manual.
- For individuals with a history of multiple relapses, re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.
- Comprehensive care daily by a multidisciplinary team that works under the direction of a Board-eligible/board-certified psychiatrist or addictionologist.
- A medical work-up is completed as needed or appropriate, and consults for medical problems, including pain management are available as needed.
- Daily medical function monitoring is provided including vital signs, clinical assessments and lab work.
- All medical and psychiatric evaluations consider the possibility of relevant co-morbid conditions.
- Outreach within 48 hours of admission, to existing providers and family members, to obtain needed history and other clinical information.
- Daily assessment of the patient's clinical needs is performed to determine if the patient continues to meet criteria for the current level of care.
- Treatment is provided that is focused on initial engagement in substance abuse rehabilitation and a plan developed for successful transition to less restrictive settings and community re-integration.
- Treatment is provided that includes evidence based psychosocial therapies appropriate for diagnosis.
- Family involvement at every level of treatment including treatment plan development, assessment, therapy and discharge planning.
- A family session must occur within seven days of admission
- Discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from an inpatient setting. Discharge planning will also include:
 - Recommendations and planning for the next level of care.
 - Coordinate with family, outpatient providers and community resources to allow a smooth transition to less restrictive levels of care.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Assess ability to participate in usual work or other activities.
 - Timely and clinically appropriate aftercare appointments scheduled to take place within seven days of discharge.
 - Aftercare planning and arrangement of follow-up appointments at lower level of care and/ or other social services or community resources as needed.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until scheduled aftercare medication management.
 - A comprehensive discharge summary is completed and in treatment record within 10 business days of the patient's discharge to include admission date, presenting problem, care summary, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Inpatient Hospitalization - Adult

Definition:

Acute inpatient substance use disorders treatment provides intensive psychiatric, medical, and nursing care and monitoring 24 hours a day, seven days a week in an inpatient setting for individuals without the need for acute detoxification treatment but that cannot be safely maintained in a substance abuse residential treatment setting. Treatment is provided by a multidisciplinary team in an acute setting to closely monitor behavioral, medical, psychiatric, or potential detox symptoms until the individual can safely be treated at a lower level of care.

Substance Use Disorder Inpatient Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorder Inpatient programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Substance Use Disorder Inpatient treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment and therapeutic care, which will include:
 - An evaluation completed by a psychiatrist or addictionologist, within 24 hours of admission
 - An individualized treatment plan is completed within 24 hours of admission and developed according to treatment record standards established in the related Provider Administration manual, and updated as needed and at least weekly.
 - For individuals with a history of multiple re-admissions, and treatment episodes, the treatment and discharge plan needs to include clear interventions to identify and address the reasons for previous non-adherence/ poor response and clear interventions for the reduction of future risks
 - Comprehensive care daily by a multidisciplinary team that works under the direction of a board-eligible/board-certified psychiatrist or addictionologist
 - A medical work-up is completed as needed or appropriate, and consults for medical problems, including pain management are available as needed
 - Monitor daily medical functioning including vital signs, clinical assessments, and labwork
 - Consideration of possible relevant co-morbid conditions should be included on all medical and psychiatric evaluations.
 - Outreach, within 48 hours of admission, to existing providers and family members, to obtain needed history and other clinical information
 - A daily assessment of the patient's clinical needs to determine if the patient continues to meet criteria for the current level of care.
 - Treatment will include evidence based psychosocial therapies appropriate for diagnosis
 - Family involvement at every level of treatment including treatment plan development, assessment, therapy and discharge planning.
 - A family session must occur within seven days of admission.
- Discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from an inpatient setting. Discharge planning will also include:
 - Recommendations and planning for the next level of care.
 - Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports.
 - Assess ability to participate in usual work or other activities.
 - Timely and clinically appropriate aftercare appointments scheduled to take place within seven days of discharge.
 - Aftercare planning and arrangement of follow-up appointments at lower level of care and/ or other social services or community resources as needed
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until scheduled aftercare medication management.
 - Referrals for community assistance and supports as needed.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Intensive Outpatient Program - Adolescent

Definition

Intensive Outpatient Programs (IOP) for Substance Use Disorders for individuals under age 18 deliver structured, time-limited, multi-disciplinary treatment to individuals with substance use disorders who can be safely treated in an outpatient setting. IOP services may be hospital-based or provided at freestanding facilities. These programs provide a minimum of at least three hours per day of treatment, two to days per week. IOPs primarily use a group format and are intended for individuals who require multimodal treatment that cannot be provided in a traditional outpatient setting. The range of services may include group, individual, and family psychotherapy, as well as psychoeducational activities. The program may function as a step-down program from higher levels of care.

Substance Use Disorder Intensive Outpatient Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorder Intensive Outpatient Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Substance Use Disorder Intensive Outpatient Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Program must be under the supervision of a licensed clinician and/or psychiatrist.
- An assessment of clinical need is completed (face-to-face) that includes both the child/ adolescent and parents/family within seven days prior to admission by a licensed clinician with training and experience related to the treatment of children and adolescents and includes an assessment of psychiatric issues, substance use disorders, medical co-morbidities and other psychosocial factors.
- Individualized treatment plan, including pre-discharge planning, is completed within three days of admission into the program and updated at least every eight IOP sessions or more frequently as needed.
- The initial assessment, the treatment planning process, as well as the entire course of treatment will include family involvement. Family therapy (face- to-face) is vital to treatment and is expected unless it is contraindicated.
- Education for the client's parents or guardians regarding substance abuse and associated problems.
- Substance use disorders education for the client.
- Linkage to community resources and supports, including community recovery resources (i.e. 12 Step programs or support groups)
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse; planning for ongoing substance abuse services.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and support.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of the patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Intensive Outpatient Program - Adult

Definition:

Intensive Outpatient Programs (IOP) for Substance Use Disorders deliver structured, time-limited, multi-disciplinary treatment to individuals with substance use disorders who can be safely treated in an outpatient setting. IOP services may be hospital-based or provided at free-standing facilities. These programs provide a minimum of at least three hours per day of treatment, 2-5 days per week. IOPs primarily use a group format and are intended for individuals who require multi-modal treatment that cannot be provided in a traditional outpatient setting. The range of services may include group, individual, and family psychotherapy, as well as psychoeducational activities. The program may function as a step-down program from higher levels of care.

Substance Use Disorder Intensive Outpatient Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorder Intensive Outpatient Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Substance Use Disorder Intensive Outpatient Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Program must be under the supervision of a licensed clinician and/or psychiatrist.
- An assessment of clinical need by a licensed clinician has been completed (face-to-face) within seven days prior to admission including an assessment of psychiatric issues, substance use disorders, medical co-morbidities and other psychosocial factors.
- Individualized treatment plan, including pre-discharge planning, is completed within three days of admission into the program and updated at least every eight IOP sessions or more frequently as needed.
- The initial assessment, the treatment planning process, as well as the entire course of treatment will include family involvement. Family therapy (face-to-face) is vital to treatment and is expected unless it is contraindicated.
- Substance use disorders education for clients and families.
- Linkage to community resources and supports, including community recovery resources (i.e. 12 Step programs or support groups).
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse; planning for ongoing substance abuse services.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of the patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments and signature of the person preparing the summary.

Substance Use Disorders Partial Hospitalization Program - Adolescent

Definition:

Substance Use Disorder Partial Hospitalization Programs deliver structured, non-residential and time limited treatment for individuals under age 18 with acute substance use disorder symptoms. These individuals should be able to maintain personal safety within the community. This setting provides treatment similar in intensity and nature to an inpatient hospital setting and includes both nursing and medical interventions. Partial hospitalization programming typically occurs three to seven days a week and between four to six hours per day.

Substance Use Disorder Partial Hospitalization Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorder Partial Hospitalization Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Substance Use Disorder Partial Hospitalization Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment by a licensed clinician within the first 24 hours to identify presenting problems such as, medical conditions, cause of admission and co-morbidities, as well as, any identified barriers for returning to routine outpatient care.
- An individualized treatment plan must be developed within the first 24 hours of treatment.
- A structured program that includes individual, family and group therapy sessions.
- Training on coping skills that are closely related to presenting problems (e.g., symptom management, problem solving, etc.).
- Psychiatric monitoring and evaluation throughout the duration of the program.
- Medication management, if indicated.
- Patient education associated with the presenting problems (e.g., diagnosis, symptoms, medication, risk factors and warning signs of relapse, etc.).
- Parental/Family involvement in interventions and education.
- Assessment and referral for any identified social service needs.
- Coordination with school and other entities.
- Discharge planning begins at admission and includes:
 - Planning and recommendations for the next appropriate level of care.
 - Safety/crisis planning with family involvement and any additional support system.
 - Family and patient education regarding diagnosis, medications, symptoms, signs of relapse and identified risk factors.
 - Assessment of capability to participate in daily activities including work or school.
 - Preparation for continuous substance abuse services and/or screenings.
 - Coordination of follow-up appointments and aftercare planning including, psychotherapy appointments, medication management, medical appointments, and referrals to any other community resources.
 - Provide psychotropic and physical health medications and/or prescriptions in adequate amount until scheduled medication management appointment.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of a patient's discharge. The discharge summary should include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Partial Hospitalization Program - Adult

Definition:

Substance Use Disorder Partial Hospitalization Programs deliver structured, non-residential and time limited treatment for individuals with acute substance use disorder symptoms. These individuals should be able to maintain personal safety within the community. This setting provides treatment similar in intensity and nature to an inpatient hospital setting and includes both nursing and medical interventions. Partial hospitalization programming typically occurs three to seven days a week and between four to six hours per day.

Substance Use Disorder Partial Hospitalization Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorder Partial Hospitalization Programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Substance Use Disorder Partial Hospitalization Programs treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Assessment by a licensed clinician within the first 24 hours to identify presenting problems such as, medical conditions, cause of admission and co-morbidities, as well as, any identified barriers for returning to routine outpatient care.
- An individualized treatment plan must be developed within the first 24 hours of treatment.
- A structured program that includes individual, family and group therapy sessions.
- Training on coping skills that are closely related to presenting problems (e.g., symptom management, problem solving, etc.).
- Psychiatric monitoring and evaluation throughout the duration of the program.
- Medication management, if indicated.
- Patient education associated with the presenting problems (e.g., diagnosis, symptoms, medication, risk factors and warning signs of relapse, etc.).
- Family involvement and education with patient consent.
- Assessment and referral for any identified social service needs
- Discharge planning begins at admission and includes:
 - Planning and recommendations for the next appropriate level of care
 - Safety/crisis planning with family involvement and any additional support system
 - Family and patient education regarding diagnosis, medications, symptoms, signs of relapse and identified risk factors
 - Assessment of capability to participate in daily activities including work or school
 - Preparation for continuous substance abuse services and/or screenings
 - Coordination of follow-up appointments and aftercare planning including, psychotherapy appointments, medication management, medical appointments, and referrals to any other community resources
 - Provide psychotropic and physical health medications and/or prescriptions in adequate amount until scheduled medication management appointment.
 - A comprehensive discharge summary is completed and available in treatment record within 30 days of patient's discharge. The discharge summary should include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Residential Treatment - Adolescent

Definition:

Substance Use Disorders Residential Treatment is a level of care that provides medical monitoring and nursing services 24 hours/day, seven days/week. Residential care for patients who are under age 18 includes staff supervision seven days per week/24 hours per day and includes school to keep residents on-track with their educational requirements. Substance Use Disorders residential care uses a multidisciplinary treatment team to address therapeutic needs and development of adaptive and functional behavior necessary to maintain sobriety at a lower level of care. Treatment includes a range of diagnostic and therapeutic behavioral health and addiction-related rehabilitation services that cannot be provided through existing community programs. Residential care provides a structured, safe environment for treatment but with less intensive supervision and monitoring than the inpatient level of care. Therefore, individuals in residential care need more structure than can be achieved with outpatient levels of care however are stable enough to participate in treatment at this level of structure.

Substance Use Disorders Residential Programs adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorders Residential programs will also adhere to all contractual guidelines including those in the Provider Administration Manual. Treatment record standards for all behavioral health providers are in the Provider Administration Manual, and Substance Use Disorders Residential treatment records will comply with those standards as well the Program Expectations outlined below:

Program Expectations:

- Substance Use Disorders Residential Treatment Facilities are staffed by a multidisciplinary treatment team under the leadership of a board-certified/board-eligible psychiatrist or addictionologist who conducts a face-to-face evaluation with each patient within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
- For individuals under the age of 18 who present with a substance use disorder, a face-to-face psychosocial assessment that includes both the child/adolescent and the family is completed within 72 hours of admission by a licensed behavioral health professional with training and experience consistent with the age and problems of children and adolescents.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.
- A psychiatrist is available 24/7, and a nurse is always on site to assess and treat medical and psychiatric issues, administer medications as clinically indicated and assist with crisis intervention.
- Medical and psychiatric evaluations that consider possible relevant comorbid conditions.
- Within 72 hours of admission, a Comprehensive Treatment Plan is to be created for the patient and updated monthly that includes:
 - A central focus on the symptoms and the issues leading to the admission for improvement toward allowing treatment to continue at a less restrictive level of care.
 - Multidisciplinary evaluations of issues related to behavior, medical condition(s), substance misuse, personality traits, social support system, educational needs and living environment.
 - Consideration of possible relevant co-morbid conditions is part of all psychiatric and medical evaluations.
 - Face-to-face weekly therapy sessions with family/significant others or, if the family/significant others live(s) greater than three hours from the treatment facility, weekly telephone contact for family therapy is to be conducted and documented to include notes to explain the patient's or family's absences or lack of participation.
 - Specific, measurable, realistic and achievable goals.
 - The comprehensive treatment plan is to:
 - Be jointly created with the patient and family/significant others.
 - Include multidisciplinary evaluations and recommendations.
 - Include treatment interventions to appropriately address the patient's clinical needs.
 - Treatment and discharge plans for patients with a history of multiple relapses, readmissions and treatment episodes need to have specific interventions to identify and address the rationales for previous non-adherence/poor responses and specific actions for the reduction of the same risks for the future.
- Treatment will include evidence based psychosocial therapies appropriate for diagnosis to include individual therapy at least once weekly, or more frequently as clinically indicated, and group therapy at least five times a week. Individualized progress notes will be documented for all individual and group therapeutic encounters, to include notes to explain the patient's absences or lack of participation.
- Residential treatment will have a program schedule that includes daily interventions and activities related to treatment goals. Daily individualized progress notes will document the patient's level of participation in treatment programming, compliance with recommendations and behavior in the milieu.
- The facility can quickly assess and address any urgent behavioral and/or medical concerns.

- As a transitional service, the purpose of residential treatment is to return the individual to the community with ongoing outpatient services as needed.
 - At the residential level of care, treatment is not primarily focused on maintaining long-term gains made in earlier programs.
 - The duration of residential treatment is not based on a preset length of stay.
 - The length of stay for some standardized programs (i.e., a “30- Day Treatment Program”) is not considered at this level of care in the review and authorization process as a criterion of medical necessity for admission and/or for concurrent stay.
- It is optimal that residential treatment occurs as close to the home and community to which the individual will be discharged. If it is not possible to place the patient close to home/community, consistent family involvement with the individual, regular family therapy sessions, and discharge planning sessions are essential, unless such involvement is clinically contraindicated.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.
- The involvement of the patient and family/significant others in a timely, consistent basis is very important and expected at each phase of treatment planning, unless it would not be in compliance with existing state/federal laws or would be clinically contraindicated. Patient and family involvement is integral in the following contexts:
- Assessment Providing detailed initial history to describe and explain the precipitating events, current and past, leading up to the admission.
- Face-to-face Family Therapy to occur at least weekly, unless clinically contraindicated.
 - Telephone contact for family therapy is acceptable, if the family lives more than three hours from the facility, and must be conducted at least weekly along with face-to-face family sessions occurring monthly.
 - Telephonic sessions are not to be considered as an equal substitute for face-to-face sessions or to be based on the convenience of the provider or family, or for the patient’s comfort.
 - Discharge planning.
- Discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from residential setting. Discharge planning will include:
 - Recommendations and planning for the patient’s next level of care
 - Communication and coordination, prior to discharge, with resources in the community to promote and aid a smooth transition back to home, family, work Recommendations and planning for the next level of care.
 - Coordination with community resources to facilitate a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient’s diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports. Confirm the patient received written instruction for what to do in the event that a crisis arises prior to the first after-care appointment.
 - Assess the ability to participate in usual work or other activities.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until scheduled aftercare medication management.
 - Confirm the patient or authorized representative understands the discharge plan.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of a patient’s discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient’s condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Substance Use Disorders Residential Treatment - Adult

Definition:

Substance Use Disorders Residential Treatment is level of care that provides medical monitoring and nursing services 24/7. The residential treatment center units and sleeping areas are generally not locked units, although, in response to the clinical or medical needs of a particular patient, they may at times be locked when necessary.

Substance Use Disorders residential care uses a multidisciplinary treatment team to address therapeutic needs and development of adaptive and functional behavior necessary to maintain sobriety at a lower level of care. Treatment includes a range of diagnostic and therapeutic behavioral health and addiction-related rehabilitation services that cannot be provided through existing community programs. Residential care provides a structured, safe environment for treatment but with less intensive supervision and monitoring than the inpatient level of care. Therefore, individuals in residential care need more structure than can be achieved with outpatient levels of care however are stable enough to participate in treatment at this level of structure.

Substance Use Disorders Residential Programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Substance Use Disorders Residential programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Substance Use Disorders Residential treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Substance Use Disorders Residential Treatment Facilities are staffed by a multidisciplinary treatment team under the leadership of a board-certified/board-eligible psychiatrist or addictionologist who conducts a face-to-face interview with each individual within 72 hours of admission and as frequently as clinically indicated throughout the duration of the admission, but no less than once weekly.
- A psychiatrist is available 24/7, and a nurse is always on site to assess and treat medical and psychiatric issues, administer medications as clinically indicated and assist with crisis intervention.
- Within 72 hours of admission, a Comprehensive Treatment Plan is to be created for the patient that includes:
 - A central focus on the symptoms and the issues leading to the admission for improvement toward allowing treatment to continue at a less restrictive level of care.
 - Multidisciplinary evaluations of issues related to behavior, medical condition(s), substance misuse, personality traits, social support system, educational needs, and the living environment.
 - The consideration of possible relevant co-morbid conditions is to be part of all psychiatric and medical evaluations.
 - Face-to-face weekly therapy sessions with family/significant others or, if the family/ significant others live(s) greater than three hours from the treatment facility, weekly telephone contact for family therapy is to be conducted and documented to include notes to explain the patient's or family's absences or lack of participation.
 - Specific, measurable, realistic and achievable goals.
- The comprehensive treatment plan is to:
 - Be jointly created with the patient and the family/significant others.
 - Include multidisciplinary evaluations and recommendations.
 - Include treatment interventions to appropriately address the clinical needs of the patient.
 - Treatment plans and discharge plans for patients with a history of multiple relapses, readmissions and treatment episodes need to have specific interventions to identify and address the rationales for previous non-adherence/poor responses and specific actions for the reduction of the same risks for the future.
- Treatment will include evidence based psychosocial therapies appropriate for diagnosis to include individual therapy at least once weekly, or more frequently as clinically indicated, and group therapy at least five times a week. Individualized progress notes will be documented for all individual and group therapeutic encounters, to include notes to explain the patient's absences or lack of participation.
- Residential treatment will have a program schedule that includes daily interventions and activities related to treatment goals. Daily individualized progress notes by residential unit staff will

document the patient's level of participation in treatment programming, compliance with recommendations/instructions and behavior in the unit milieu.

- The facility can quickly assess and address any urgent behavioral and/or medical concerns.
- As a transitional service, the purpose of residential treatment is to return the individual to the community with ongoing outpatient services as needed.
 - At the residential level of care, treatment is not primarily focused on maintaining long-term gains made in earlier programs.
 - The duration of residential treatment is not based on a preset length of stay.
 - The length of stay for some standardized programs (i.e., a “30- Day Treatment Program”) is not considered at this level of care in the review and authorization process as a criterion of medical necessity for admission and/or for concurrent stay.
- It is optimal that residential treatment occurs as close to the home and community to which the individual will be discharged. If it is not possible to place the patient close to home/community, consistent family involvement with the individual, regular family therapy sessions, and discharge planning sessions are essential, unless such involvement is clinically contraindicated.
- Outreach is performed with existing providers and family members within 72 hours of admission to obtain necessary historical and other pertinent clinical information.
- The involvement of the patient and family/significant others in a timely, consistent basis is very important and expected at each phase of treatment planning, unless it would not be in compliance with existing state/federal laws or would be clinically contraindicated. Patients and family involvement is integral in the following contexts:
 - Assessment providing detailed initial history to describe and explain the precipitating events, current and past, leading up to the admission.
 - Face-to-face Family Therapy to occur at least weekly, unless clinically contraindicated.
 - Telephone contact for family therapy is acceptable, if the family lives more than three hours from the facility, and must be conducted at least weekly along with face-to-face family sessions occurring monthly.
 - Telephonic sessions are not to be considered as an equal substitute for face-to-face sessions or to be based on the convenience of the provider or family, or for the patient's comfort.
 - Discharge planning.
- Discharge planning will begin at the point of admission with the expectation that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from residential setting. Discharge planning includes:
 - Recommendations and planning for the patient's next level of care.
 - Communication and coordination, prior to discharge, with resources in the community to promote and aid a smooth transition back to home, family, work or school, and appropriate outpatient treatment services.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Safety/crisis planning with involvement of family and/or other supports. Confirm the patient received written instruction for what to do in the event that a crisis arises prior to the first after-care appointment.
 - Assess the patient's ability to participate in usual work and/or other activities.
 - Medication or prescriptions (psychotropic and physical health) in sufficient quantity to last until scheduled aftercare medication management.
 - Confirm the patient or authorized representative understands the discharge plan.
 - A comprehensive discharge summary is completed and available in treatment record within 10 business days of a patient's discharge to include admission date, presenting problem, summary of care, the reason for discharge, patient's condition at the time of discharge, all aftercare recommendations including scheduled appointments, and signature of the person preparing the summary.

Supported Housing - Enhanced

Definition:

Supported housing refers to services rendered at facilities staffed 24/7 with mental health practitioners and is for priority patients who require treatment services and supports in a highly structured setting. Supported housing services are for mental health services only and do not include payment for room and board.

Enhanced supported housing facilities are for individuals requiring care exceeding the support and intervention level in routine supportive housing, who cannot be safely maintained in routine supported housing, and/or who have had unsuccessful tenure in routine supported housing. The need for Enhanced Supported Housing relates to one or more of the following: 1) a medical condition requiring additional assistance (e.g. diabetes, cancer, TB, eating disorder, etc.); 2) a co-occurring condition such as lower cognitive functioning and cognitive decline that necessitates additional assistance; 3) requires a more secure setting due to elopement and wandering behaviors; 4) is not able to be maintained in regular Supported Housing services due to a lack of medication adherence, increased symptomology and problematic behaviors in the community.

Enhanced supported housing facilities will be equipped with additional safety precautions and more direct staff availability than routine supported housing. Enhanced supported housing services prepare individuals for routine supported housing and/or independent living in the community.

Enhanced Supported Housing programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Enhanced Supported Housing programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Enhanced Supported Housing treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Facility provides a residential setting staffed 24 hours a day, seven days a week with associated mental health staff supports for seriously and persistent mentally ill (SPMI) individuals who are 18 years or older, who require services in a structured setting to maintain successful community tenure.
- Facility provides safety measures beyond that of routine supported housing to meet safety needs of population served. Some examples include, but are not limited to, lock or alarmed doors, additional staff for supervision, and more structured activities tailored to the needs of residents.
- Utilize a strengths model to assist individuals to live in a structured community setting with appropriate mental health supports as they function and progress toward individualized recovery goals.
- Complete a thorough initial assessment of care needs to include psychiatric, medical and psychosocial needs.
- Development of an individualized treatment plan within the first 30 days of services that includes clear goals/objectives for recovery and discharge, that is updated/ revised at least every six months, and that adheres to all treatment record standards outlined in the Behavioral Health Care Services section of the related Provider Administration Manual. Treatment goals will be targeted toward patient moving to routine supported housing and back into the community.
- Development of an individualized crisis plan to include the availability of housing staff 24/7, family and other natural supports, emergency services, as well as other behavioral health providers if applicable with evidence of patient input and understanding.
- Provision of coordinated services focusing on rehabilitation to fit the needs of the resident such as individual, group and family counseling, psychosocial training, vocational training and skill building.
- Daily documentation of the patient's behavior in the residential milieu and weekly documentation of the patient's progress toward treatment goals.
- Provision of medical and nursing services as needed according to the patient's individual treatment plan.
- Active family/significant other involvement, unless contraindicated, will occur based on individual needs. Residents may go into the community for work, school, and/or outside activities.
- Community resources are used in a planned, purposeful, and therapeutic way to encourage autonomy.
- Provision of coordination toward transitioning individuals with SPMI from child/ adolescent services to adult continuum of services and assistance for them to remain in the community while accessing community based services.
- Discharge planning throughout care to include:
 - Recommendations and planning for the next level of care
 - Prepare for and coordinate with the next residence to include other supported housing group homes or caretakers in the community.
 - Safety/crisis planning with involvement of family and/or other supports.

- Planning for ongoing substance abuse screenings or services if appropriate.
- Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse
- Assessment of patient's ability to participate in community, work, or other activities.
- Aftercare planning and arrangement of outpatient appointments such as IOP, psychiatric medication management appointments, psychotherapy appointments, medical appointments, and/or other social services or community resources as indicated.

Supported Housing – Medically Fragile

Definition:

Supported housing refers to services rendered at facilities staffed 24/7 with mental health practitioners and is for priority patients who require treatment services and supports in a highly structured setting. Supported housing services are for mental health services only and do not include payment for room and board.

Medically Fragile Supported Housing facilities are for individuals who have a medical condition requiring daily medical assistance in the form of specialized care (e.g. nursing, health technicians, durable medical equipment, etc.). This level of care is intended for individuals who are not able to be maintained in Routine Supported Housing or Enhanced Supported Housing due to the needs arising from their medical condition.

Additional medical staff and accommodations such as wheelchair accessible showers and others over and above regular or Enhanced Supported Housing are provided for day-to-day care. Included in the assessment, planning, implementation, and evaluation of care are: physical assessment, complete medical and behavioral history and treatment record, current diagnoses and medications, comorbidities, degree of severity of disorders/diseases, safety and crisis plans, risk factors including SI/HI, substance abuse, sexual abuse or trauma, functional impairments and needed supports/modifications/accommodations, job/school history, family history of mental illness, family member/community support, participating physicians as evidenced by written consent, expected outcomes, and follow-up care as needed.

Medically Fragile Supported Housing programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Medically Fragile Supported Housing programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers are in the Provider Administration Manual, and Medically Fragile Supported Housing treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Facility provides a residential setting staffed 24 hours a day, seven days a week with associated mental health staff supports for medically fragile individuals who are 18 years old or older, who require services in a community-based setting to successfully maintain their level of health that may need occasional or continual technical support.
- Facility provides safety measures beyond that of enhanced supported housing to meet safety needs of population it serves. Some examples include, but are not limited to, lock or alarmed doors, wheelchairs, additional staff for supervision, and more structured activities tailored to the needs of residents.
- Use a strengths model to assist individuals to live in a structured community setting with appropriate mental health supports as they function and progress toward individualized recovery goals.
- Complete a thorough initial assessment of care needs to include psychiatric, medical and psychosocial.
- Development an individualized treatment plan within the first 30 days of services that includes clear goals/objectives for recovery and discharge, that is, updated/revised at least every six months, and that adheres to all treatment record standards outlined in the Behavioral Health Care Services section of the related Provider Administration Manual. Treatment goals will be targeted toward patient moving to enhanced supported housing and back into the community.
- Development of an individualized crisis plan to include the availability of housing staff 24/7, family and other natural supports, emergency services, as well as other behavioral health providers if applicable with evidence of patient input and understanding.
- Provision of coordinated services focusing on rehabilitation to fit the needs of the resident such as individual, group, and family counseling, psychosocial training, vocational training, and skill building.
- Daily documentation of the patient's behavior in the residential milieu and weekly documentation of the patient's progress toward treatment goals.
- Provision of medical and nursing services as needed according to the patient's treatment plan.
- Active family/significant other involvement, unless contraindicated, will occur based on individual needs. Residents may go into the community for work, school, and/or outside activities as they are able.
- Planned, purposeful and therapeutic community resources that encourage autonomy when possible.
- Provision of coordination toward transitioning medically fragile through continuity of care in the community while accessing community based services.

- Discharge planning throughout care to include:
 - Recommendations and planning for the next level of care
 - Prepare and coordinate with the next residence to include other supported housing group homes or caretakers in the community.
 - Safety/crisis planning with involvement of family and/or other supports
 - Planning for ongoing substance abuse screenings or services if appropriate
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse
 - Assessment of patient's ability to participate in community, work or other activities.
 - Aftercare planning and arrangement of outpatient appointments such as IOP, psychiatric medication management appointments, psychotherapy appointments, medical appointments, and/or other social services or community resources as indicated.

Supported Housing - Routine

Definition:

Supported housing services refer to transitional services rendered at facilities that provide 24-hour awake staffing with behavioral health staff supports for individuals who require treatment services and supports in a highly structured, safe, and secure setting. Supported housing services are for TennCare Priority Enrollees and are intended to prepare individuals to live independently in a community setting. At a minimum, supported housing services include coordinated and structured personal care services to address the individuals' behavioral and physical health needs in addition to 15 hours per week of psychosocial rehabilitation services to assist individuals achieve recovery and resiliency based goals and develop the life skills necessary to live independently in a community setting. Supported housing services do not include room and board payment.

Supported Housing programs will adhere to all standards and regulations set forth by their licensing and accreditation entities. Supported Housing programs will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and Supported Housing treatment records will comply with those standards as well as the Program Expectations outlined in the following:

Program Expectations:

- Provides a residential setting staffed 24/7 with associated mental health staff supports for seriously and persistent mentally ill (SPMI) individuals who are 18 years or older, who require services in a structured setting to maintain successful community tenure.
- Uses a strengths model to assist individuals to live in a structured community setting with appropriate mental health supports as they function and progress toward individualized recovery goals.
- Develops an individualized treatment plan within the first 30 days of services that includes clear goals/objectives for recovery and discharge, that is updated/revised at least every six months, and that adheres to all treatment record standards outlined in the Behavioral Health Care Services section of the related Provider Administration Manual.
- Development of an individualized crisis plan to include the availability of housing staff 24/7, family and other natural supports, emergency services, as well as other behavioral health providers if applicable with evidence of the patient's input and understanding.
- Provide coordinated services focused on rehabilitation to fit the resident's needs: individual, group and family counseling, psychosocial training, vocational training and skill building.
- Provides daily documentation of the patient's behavior in the residential milieu and weekly documentation of his or her progress toward treatment goals.
- Provides medical and nursing services as needed on a consultative basis.
- Active family/significant other involvement, unless contraindicated, will occur based on individual needs. Residents may go into the community for work, school, and/or outside activities.
- Provides coordination so individuals will be integrated into the community at a level commensurate with the strengths and abilities of the individual as documented in the individuals' treatment plan. Planned, purposeful and therapeutic community resources are used that encourage autonomy.
- Provides coordination toward transitioning individuals with SPMI from child/ adolescent services to adult continuum of services and assistance for them to remain in the community while accessing community based services.
- The expectation is that individuals will develop skills that foster independence and support the individual's recovery plan and discharge goals.
- Discharge planning begins at admission and includes:
 - Recommendations and planning for the next level of care and coordination with outpatient providers and community supports.
 - Safety/crisis planning with involvement of family/othersupports.
 - Patient and family education regarding patient's diagnosis, symptoms, medications, risk factors and warning signs of relapse.
 - Assessment of ability to participate in usual work or other activities.
 - Aftercare planning and arrangement of follow-up appointments with outpatient providers within 14 days of discharge, unless not clinically indicated.
 - Referrals for community assistance and supports.

Transcranial Magnetic Stimulation (TMS)

Description:

Transcranial magnetic stimulation (TMS) is a treatment for Major Depressive Disorder (MDD). BlueCross BlueShield of Tennessee authorizes TMS only regarding the confirmed diagnosis of a MDD when the TMS medical necessity criteria are met.

TMS is a noninvasive method of delivering electrical stimulation to the brain. When TMS is delivered through rapid repetitive stimulation, it is referred to as repetitive transcranial magnetic stimulation (rTMS). A treatment course is usually one daily session, five times per week for up to six weeks, followed by a three-week taper of three rTMS sessions in week one, two rTMS sessions the next week, and one rTMS session in the last week (total of 36 sessions). The goal for rTMS is to stimulate nerve cells in the brain believed to be associated with mood regulation (i.e. left prefrontal cortex) and relieve the symptoms of depression.

Repetitive transcranial magnetic stimulation (rTMS) of the brain for the treatment of MDD may be considered medically necessary if the medically appropriateness criteria are met. Providers of TMS services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Providers of TMS services will also adhere to all contractual guidelines including all guidelines in the PAM. Treatment record standards for all behavioral health services can be found in the PAM, and all TMS treatment records will comply with those standards.

Note: It is the policy of BlueCross that the following similar therapies are considered investigational and are not currently authorized services: cranial electrotherapy stimulation (CES), navigated transcranial magnetic stimulation (nTMS), and continued treatment with rTMS as maintenance therapy.

Program Expectations:

- An initial psychiatric evaluation must be performed by the provider before initiating rTMS treatment and will include a psychiatric history, prior psychotropic medications, co-occurring conditions, current medications (psychotropic and physical medications), mental status exam, current DSM diagnoses, history of response to TMS or rTMS in a previous depressive episode (if applicable), SI/HI/psychoses assessments and an updated treatment plan with measurable and attainable goals.
- The patient's medical record will document the elements of medical appropriateness reported by the provider at the time of the pre-cert/authorization process. The medical record will also contain a documented progress note by both the physician and the attendant for each rTMS session provided.
- The attending physician is required to have completed a psychiatry residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the Royal College of Physicians and Surgeons of Canada (RCPSC); Board certification in psychiatry by the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Board of Psychiatry and Neurology (AOBPN) is preferred.
- The attending physician must have completed the course in TMS approved by the device manufacturer or a university-based course in TMS.
- The device which supplies the treatment must be approved or cleared by the Food and Drug Administration (FDA) for the purpose of providing transcranial magnetic stimulation for this indication.
- There must be immediate access to emergency equipment which includes a cardiac defibrillator, oxygen and suction, which must remain operable and available to the patient throughout TMS sessions.
- To monitor responses to treatment and any remission of symptoms, the treating physician must use evidence-based validated depression monitoring scales such as the Geriatric Depression Scale (GDS), the Personal Health Questionnaire Depression Scale (PHQ-9), the Beck Depression Scale (BDI), the Hamilton Rating Scale for Depression (HAM-D), the Montgomery Asberg Depression Rating Scale (MADRS), the Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR), or the Consumer Health Inventory (CHI).
- Supervision of treatment:
 - TMS treatment is to be given under direct supervision of the attending physician who must be immediately available and on-site. The physician will assess the patient at each session, but is not required to provide the treatment. The patient's clinical progress during the treatment must be monitored and documented by the physician.
 - Personal supervision is to be provided by the attending physician for the initial motor threshold determinations, treatment parameter definition, and TMS treatment course planning and documentation supportive of the level of supervision.
 - Either the attendant or attending physician must be present with the patient for the duration of each TMS session. The attendant must be trained in:

- Basic Life Support (BLS) certified
- The management of complications such as seizures
- The application of the TMS apparatus.
- Any change in the patient's mental status during initial or subsequent sessions and/or other significant change in his or her clinical status require a face-to-face assessment with the physician. If clinically indicated, the patient is to be released into the care of a responsible adult who can provide supportive care and monitor him or her as necessary.
- Coordinated care with the member's PCP, as well as with the patient's referring providers, must be documented in the patient's treatment record. Information to be communicated includes diagnoses by referring provider, psychiatric history, co-occurring conditions, response to treatment and discharge planning.

Discharge planning

- Discharge planning begins with the initial rTMS session and includes referrals to aftercare providers and coordination of care regarding the patient's responses to rTMS treatment and any recommendations by the attending physician.

