TOC required

215.330 Acute Inpatient Mental Health 5-1-15

Acute inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. Twenty-four hour skilled nursing care, daily medical evaluation and management (preferably a child psychiatrist for children under 12), and a structured treatment milieu are required. Inpatient service settings must provide an initial visit with an attending physician within 24 hours of admission for evaluation and treatment planning, and a documented daily visit with an attending licensed prescribing provider.

The goal of acute inpatient care is to stabilize beneficiaries who display acute psychiatric conditions associated with a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the beneficiary poses a significant danger to self or others, or displays severe psychosocial dysfunction. Special treatment may include physical and mechanical restraint, seclusion, and a locked unit. Active family, legal guardian or custodian involvement is important unless contraindicated. Estimated length of stay is based on individual needs that must be documented in treatment plans.

215.331 Admission Criteria for Acute Inpatient Mental Health 5-1-15

The following criteria are necessary for admission:

A. The beneficiary has been evaluated by a master's level licensed clinician or licensed registered nurse (R.N.) with at least three (3) years supervised experience in a mental health setting, who demonstrates acute psychiatric symptomatology consistent with a DSM-IV-TR (or subsequent revisions) diagnosis that requires and can reasonably be expected to respond to therapeutic intervention.

B. There is evidence of actual or potential danger to self or others, or severe psychosocial dysfunction, as evidenced by at least one of the following (1-10):

1. A suicide attempt that is serious by degree of lethality and intentionally or suicidal ideation with a plan and means. However, 23-hour observation may be used initially to rule out presence of acute psychiatric symptomatology and/or as a result of intoxication. Assessment should include an evaluation of:
    a. The circumstances of the suicide attempt or ideation, was beneficiary able to reach out for help after the attempt, were others present, was beneficiary found unconscious, etc.
    b. The method used or contemplated, was this realistic in the context of access to the method.
    c. Statements made by the individual.
    d. The presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses.
    e. Availability of responsible support systems.
    f. Impulsive behavior and/or concurrent intoxication increase the need for consideration of this level of care.
2. Current assaultive threats or behavior, resulting from a mental health disorder, with a clear risk of escalation or future repetition (i.e., has a plan and means).
3. History immediately prior to admission prompting evaluation or intake of significant self-mutilation (non-chronic), significant risk-taking, or loss of impulse control resulting in danger to self or others.

4. History immediately prior to admission, prompting evaluation or intake of violence resulting from an Axis I disorder.
5. Past attempt with medical compromise or injury.
6. Command hallucinations directing harm to self or others.
7. Disordered or bizarre behavior, psychomotor agitation or psychomotor retardation that interferes with the activities of daily living to such a degree that the beneficiary cannot function at a less intensive level of care.
8. Disorientation or memory impairment that is due to a mental health disorder and accompanied by severe agitation which endangers the welfare of the beneficiary or others.
9. Inability in an age-appropriate manner to maintain adequate nutrition due to a mental health disorder.
10. The beneficiary is experiencing severe or life-threatening side effects from using therapeutic psychotropic drugs.

C. The following action must occur and documentation must be placed in the beneficiary's medical record:

1. The multi-disciplinary discharge planning process is documented and starts from the assessment and tentative plan upon admission, and includes the beneficiary and active family, legal guardian or custodian involvement unless contraindicated secondary to risk of harm to beneficiary, family, legal guardian, or custodian.
2. The treatment plan must clearly state the benefits the beneficiary will receive in the program, and the goals of treatment cannot be based solely on a need for structure and lack of supports.

215.332 Exclusion Criteria for Acute Inpatient Mental Health 5-1-15

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

A. The beneficiary can be safely maintained and effectively treated at a less intensive level of care.

B. Symptoms result from a medical condition, which warrants a medical or surgical setting for treatment.

C. The beneficiary exhibits serious and persistent mental illness consistent through time and is not in an acute exacerbation of the illness.

D. The primary problem is not psychiatric (e.g., social, economic, or delinquent behavior), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

215.333 Continuing Stay Criteria for Acute Inpatient Mental Health 5-1-15

All of the following criteria are necessary for continuing treatment at this level of care:

A. The beneficiary's condition continues to meet admission criteria for inpatient care, acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate.

B. The multi-disciplinary discharge planning process is documented and starts from the assessment and tentative plan upon admission, and includes the beneficiary and active family, legal guardian, or custodian unless contraindicated secondary to risk of harm to beneficiary, family, legal guardian, or custodian.

C. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems, social, educational and interpersonal assessment with involvement unless contraindicated, within 48 hours of admission. Family sessions need to occur in a timely manner. Treatment planning goal setting should be realistic and attainable. Expected benefit from all relevant treatment modalities, including family and group treatment is documented.

D. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice.

E. Progress in relation to specific symptoms or impairment is evident and can be described in objective terms, but the goals of treatment have not yet been reached; OR a lack of progress in relation to specific symptoms or impairment is evident and is clearly documented in the progress notes and the treatment plan. Documentation reflects that adjustments to the treatment plan are being made to address the lack of progress and any psychiatric or medical complications.

G. Care is rendered in a clinically appropriate manner and focused on the beneficiary's behavioral and functional outcomes as described in the discharge plan.

H. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated and consistent with prescribing guidelines. The treatment plan is updated to address non-compliance issues.

I. The beneficiary is actively participating in the plan of care and treatment to the extent possible consistent with his or her condition, OR the beneficiary is not actively participating in treatment, but cannot be safely treated in a less restrictive setting. In this case, documentation must reflect current barriers to treatment and strategies to engage the beneficiary in treatment.

J. Coordination with relevant outpatient providers is implemented.

K. If the family, legal guardian or custodian is competent but non-participatory in treatment or in following program rules and regulations but the child is actively engaged in treatment and making progress, there should be documentation focusing on engaging the family, legal guardian or custodian. If this fails, a child maltreatment report should be contemplated.

215.334 Discharge Criteria for Acute Inpatient Mental Health 5-1-15

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

A. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a lower level of care. A follow-up aftercare appointment is arranged for a timeframe consistent with the beneficiary's condition and applicable standards.

B. The beneficiary no longer meets admission criteria or meets criteria for a less intensive level of care.

C. The beneficiary's lack of participation and progress are assessed to be symptoms of malingering and can be appropriately and safely addressed in a less restrictive or alternative setting. (If such symptoms cannot be safely addressed outside the acute setting, documentation should reflect efforts of the treatment team to minimize the beneficiary's potential for secondary gain.)

D. Either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment and ValueOptions agrees based on medical necessity criteria.

E. Consent for treatment is withdrawn and, either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment.

F. Support systems that allow the beneficiary to be maintained in a less restrictive treatment environment have been thoroughly explored and/or secured.

G. The beneficiary is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care due to exhibiting baseline behavior/symptoms of a chronic condition.

H. The beneficiary's physical condition necessitates transfer to a medical facility.

215.340 Residential Treatment Services 5-1-15

Residential Treatment Services (RTS) are provided to beneficiaries who require 24-hour treatment and supervision in a safe therapeutic environment. RTS is a 24 hour a day/7 day a week facility-based level of care. RTS provides individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming in a controlled environment with 24 hour supervision and structure. RTS addresses the identified problems through a wide range of diagnostic and treatment services, as well as through training in basic skills such as social skills and activities of daily living that cannot be provided in a community setting.

The services are provided in the context of a comprehensive, multidisciplinary and individualized treatment plan that is frequently reviewed and updated based on the individual's clinical status and response to treatment. This level of care requires at least weekly physician visits. This treatment primarily provides social, psychosocial, educational and rehabilitative training, and focuses on active family or caregiver reintegration. Active family or caregiver involvement through family therapy is a key element of treatment and is required unless contraindicated.

Discharge planning must begin at admission, including plans for reintegration into the home, school and community. If discharge to a home or family is not an option, alternative placement must be rapidly identified and there must be regular documentation of active efforts to secure such placement. The facility is expected to provide an environment and coordinate educational activities that are age appropriate.

215.341 Admission Criteria for Residential Treatment Services 5-1-15

All of the following criteria are necessary for admission:

A. The beneficiary demonstrates symptomatology consistent with a DSM-IV-TR (or subsequent revisions) diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.

B. The beneficiary is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.

C. The beneficiary demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.

D. The beneficiary has a history of multiple hospitalizations or other treatment episodes at other levels of care and/or recent inpatient stay with a history of poor treatment adherence or outcome.

E. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.

F. The family situation and functioning levels are such that the beneficiary cannot safely remain in the home environment and receive community-based treatment.

215.342 Exclusion Criteria for Residential Treatment Services 5-1-15

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

A. The beneficiary exhibits severe suicidal, homicidal, or acute mood symptoms/thought disorder, which requires a more intensive level of care.

B. The Parent or guardian does not voluntarily consent to admission or treatment.

C. The beneficiary can be safely maintained and effectively treated at a less intensive level of care.

D. The beneficiary has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications.

E. The primary problem is social or economic, such as housing, family, conflict, etc., or one of physical health without a concurrent major psychiatric episode meeting the criteria for this level of care.

F. The admission is being used for purposes of convenience or as an alternative to incarceration within the juvenile justice or protective services system, or as an alternative to specialized schooling, or simply as respite or housing.

215.343 Continued Stay Criteria for Residential Treatment Services 5-1-15

All of the following criteria are necessary for continuing treatment at this level of care:

A. The beneficiary's condition continues to meet admission criteria at this level of care.

B. The beneficiary’s treatment does not require a more intensive level of care, and no less intensive level of care is appropriate.

C. Treatment planning is individualized and appropriate to the beneficiary’s changing condition with realistic and specific goals and objectives stated. Treatment planning must include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities.

D. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice.

E. Progress in relation to specific symptoms or impairments is evident and can be described in objective terms, but the goals of treatment have not yet been reached; OR a lack of progress in relation to specific symptoms or impairment is evident and is clearly documented in the progress notes and the treatment plan. Documentation reflects that adjustments are made to address the lack of progress and any psychiatric/medical complications.

F. Care is rendered in a clinically appropriate manner and focused on the beneficiary’s behavioral and functional outcomes.

G. An individualized discharge plan has been developed and includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place, but discharge criteria have not yet been met.

H. The beneficiary is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition, OR the beneficiary is not actively participating in

treatment, but cannot be safely treated in a less restrictive setting. In this case, documentation reflects current barriers to treatment and strategies to engage the beneficiary in treatment.

I. Unless contraindicated, the family, legal guardian, or custodian is actively involved in the treatment as required by the treatment plan; or there are active efforts being made and documented to involve them.

J. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.

K. There is a documented active attempt at coordination of care with relevant outpatient providers and community support systems when appropriate.

L. If the family, legal guardian, and/or custodian are competent but non-participatory in treatment or in following program rules and regulations but the child is actively engaged in treatment and making progress, there should be documentation focusing on engaging the family. If this fails, a child maltreatment report should be contemplated.

215.344 Discharge Criteria for Residential Treatment Services 5-1-15

The following (A) is necessary for discharge from this level of care:

A. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

In addition, at least one of the following (B-F) is necessary for discharge from this level of care:

B. The beneficiary's documented treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged, and deployed at an alternate level of care.

C. The beneficiary no longer meets admission criteria, or meets criteria for a less or more intensive level of care.

D. The beneficiary's lack of participation and progress are assessed to be symptoms of malingering and can be appropriately and safely addressed in a less restrictive or alternative setting. (If such symptoms cannot be safely addressed outside the residential setting, documentation should reflect efforts of the treatment team to minimize the beneficiary's potential for secondary gain.)

E. The beneficiary is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function.

F. The beneficiary can be safely treated at an alternative level of care.