BEHAVIOR HEALTH
LEVEL OF CARE GUIDELINES
for Centennial Care MCOs

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NEW MEXICO MEDICAL NECESSITY DEFINITION:

8.302.1.7 DEFINITIONS: Medically necessary services

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:
   1. are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;
   2. are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;
   3. are provided within professionally accepted standards of practice and national guidelines; and
   4. are required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

B. Application of the definition:
   1. A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.
   2. The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient shall do so by:
      a) evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;
      b) considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
      c) considering the services being provided concurrently by other service delivery systems.
   3. Physical and behavioral health services shall not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.
   4. Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.
   5. Medically necessary service requirements apply to all medical assistance program rules.

QUALITY OF SERVICE CRITERIA:

The following criteria are common to all levels of care for behavioral health conditions and substance use disorders. These criteria will be used in conjunction with criteria for specific level of care.

1. The member is eligible for benefits.
2. The provider completes a thorough initial evaluation, including current assessment information.
3. The member's condition and proposed services are covered under the terms of the benefit plan.
4. The member's current condition can be most efficiently and effectively treated in the proposed level of care.
5. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.
6. There must be a reasonable expectation that essential and appropriate services will improve the member's presenting problems within a reasonable period of time. "Improvement" in this context is measured by weighing the effectiveness of treatment against the evidence that the member's condition will deteriorate if treatment is discontinued in the current level of care. Improvement must also be understood within the framework of the member's broader recovery goals.
7. The goal of treatment is to improve the member's presenting symptoms to the point that treatment in the current level of care is no longer required.
8. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.
9. The member has provided informed consent to treatment. Informed consent includes the following:
   a) The member has been informed of safe and effective alternatives.
   b) The member understands the potential risks and benefits of treatment.
   c) The member is willing and able to follow the treatment plan including the safety precautions for treatment.
10. The treatment/service plan stems from the member's presenting condition, and clearly documents realistic and measurable treatment goals as well as the treatments that will be used to achieve the goals of treatment. The treatment/service plan also considers the following:
    a) Use of treatments that are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.
    b) Significant variables such as the member's age and level of development; the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to treatment; the member's understanding of his/her condition, its treatment

and self-care; and the role that the member's family/social supports should play in treatment with the member's permission.

c) Interventions needed to address co-occurring behavioral health or medical conditions.

d) Interventions that will promote the member's participation in care, promote informed decision making, and support the member's broader recovery goals. Examples of such interventions are psycho-education, motivational interviewing, recovery planning and use of an advance directive, as well as facilitating involvement with natural and cultural supports, and self-help or peer programs.

e) Involvement of the member's family/social supports in treatment and discharge planning with the member's permission when such involvement is clinically indicated.

f) How treatment will be coordinated with other behavioral health and medical providers as well as within the school system, legal system and community agencies with the member's permission.

g) How the treatment plan will be altered as the member's condition changes, or when the response to treatment isn't as anticipated.

11. The discharge plan stems from the member's response to treatment, and considers the following:

a) Significant variables including the member's preferences, strengths, broader recovery goals and readiness for change; risks including barriers to care; past response to discharge; the member's understanding of his/her condition, its treatment and self-care; and the role that the member's family/social supports should play in treatment with the member's permission.

b) The availability of a lower level of care which can effectively and safely treat the member's current clinical condition.

c) The availability of treatments which are consistent with nationally recognized scientific evidence, prevailing medical standards for the treatment of the member's current condition and clinical guidelines.

d) Involvement of the member's family/social supports in discharge planning with the member's permission when such involvement is clinically indicated.

e) How discharge will be coordinated with the provider of post-discharge behavioral health care, medical providers, as well as with the school system, legal system or community agencies with the member's permission.

12. How the risk of relapse will be mitigated including:

a) Completing an accurate assessment of the member's current level of function and ability to follow through on the agreed upon discharge plan;

b) Confirming that the member has engaged in shared decision making about the discharge plan and that the member understands and agrees with the discharge plan;

c) Scheduling a first appointment within 7 days of discharge when care at a lower level is planned;

d) Assisting the member with overcoming barriers to care (e.g. a lack of transportation or child care challenges);
e) Ensuring that the member has an adequate supply of medication to bridge the time between discharge and the first scheduled follow-up psychiatric assessment;
f) Providing psycho-education and motivational interviewing, assisting with recovery planning and use of an advance directive, and facilitating involvement with self-help and peer programs;
g) Confirming that the member understands what to do in the event that there is a crisis prior to the first post-discharge appointment, or if the member needs to resume services.

13. The availability of resources, natural and cultural supports, such as self-help and peer support programs, and peer-run services which may augment treatment, facilitate the member's transition from the current level of care, and support the member's broader recovery goals.

ACUTE INPATIENT HOSPITALIZATION

I. DEFINITION OF SERVICE:

Acute Inpatient Psychiatric Hospitalization is a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment service. This level of care is for stabilization of urgent or emergent behavioral health problems. Acute Inpatient Hospitalization is provided specifically for those members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services. It is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital. The care must be provided under the direction of an attending physician who performs a face-to-face interview of the member within 24 hours of admission. The care involves an individualized treatment plan that is reviewed and revised frequently based on the member's clinical status.

This level of care should not be authorized solely as a substitute for management within the adult corrections, juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system), or simply to serve as respite or housing.

This level of care is available for all age ranges, but admission should be to a unit that is age appropriate. For school age children and youth, academic schooling funded through the local school system or by the facility is expected.

For more detailed information please reference NMAC 8.321.2.16.

II. ADMISSION CRITERIA (MEETS A AND B, AND C OR D OR E OR F OR G):

- **A.** Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, the proposed therapeutic intervention.
- **B.** Treatment cannot safely be administered in a less restrictive level of care.
- **C.** There is an indication of actual or potential imminent danger to self which cannot be controlled outside of a 24-hour treatment setting. Examples of indications include serious suicidal ideation or attempts, severe self-mutilation or other serious self-destructive actions.
- **D.** There is an indication of actual or potential imminent danger to others and the impulses to harm others cannot be controlled outside of a 24-hour treatment setting. An example of an indication includes a current threat and means to kill or injure someone.
- **E.** There is an indication of actual or potential grave passive neglect that cannot be treated outside of an acute 24-hour treatment setting.

F. There is disordered or bizarre thinking, psychomotor agitation or retardation, and/or a loss of impulse control or impairment in judgment leading to behaviors that place the member or others in imminent danger. These behaviors cannot be controlled outside of a 24-hour treatment setting.

G. There is a co-existing medical illness that complicates the psychiatric illness or treatment. Together the illnesses or treatment pose a high risk of harm for the member and cannot be managed outside of a 24-hour treatment setting.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria including the need for 24 hour medical supervision

B. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required inpatient treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities.

C. The member is making meaningful and measurable progress at the current level of care and/or the current or revised treatment plan can be reasonably expected to bring about significant improvements in the behaviors and/or symptoms leading to admission. Progress is documented toward treatment goals.

D. An individualized discharge plan has been developed which includes specific time-limited, 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.

IV. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her individualized discharge criteria.

B. The member can be safely treated at a less intensive level of care.

C. An individualized discharge plan has been developed.

D. The first aftercare appointment has been scheduled by the facility within a timeframe commensurate with the member's needs, but no later than 7 days from discharge.

V. EXCLUSIONARY CRITERIA (MAY MEET ANY):

A. The condition of primary clinical concern is one of a medical nature (not behavioral health) and, as outlined in the current Mixed Services Protocol, should be covered by another managed care entity.

B. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or inappropriate seeking of medications.

DAYS AWAITING PLACEMENT (DAP) RATE

I. Description:

Inpatient Days Awaiting Placement (DAP) is a negotiated rate used when a Medicaid eligible member no longer meets acute care criteria and it is verified that the eligible member requires a residential level of care which may not be immediately located, those days during which the eligible member is awaiting placement to the lower level of care are termed “awaiting placement days”. These circumstances must be beyond the control of the inpatient provider. **DAP is intended to be brief and to support transition to the lower level of care. DAP may not be used solely because the inpatient provider did not pursue or implement a discharge plan in a timely manner.**

For more detailed information please reference NMAC 8.321.2.16.

II. Approval Criteria (must meet all):

- **A.** The member is covered by Medicaid as administered by the Medical Assistance Division definition, and the member has a DSM diagnosed condition that has required an acute inpatient psychiatric level of care currently.
- **B.** The member no longer meets continued stay criteria for inpatient acute psychiatric care and/or does meet discharge criteria and there is a specific discharge plan in place to a residential level of care, but documented barriers to implementation of that plan exist that are beyond the control of the provider or facility.
- **C.** The provider has made reasonable efforts to identify and obtain the services needed to implement the discharge plan and continues to actively work to identify resources to implement that plan.
- **D.** The MCO has authorized the residential level of care sought as the discharge, and documentation of this authorization has been made available to MCO utilization management personnel.

III. Exclusionary Criteria:

- **A.** The member has met his/her individualized discharge criteria and substantial barriers to discharge no longer exist.
- **B.** The inpatient facility cannot demonstrate that it continues to actively work to eliminate barriers to the planned discharge.
- **C.** The inpatient facility is pursuing a discharge to a level of care or service that a MCO psychiatrist peer reviewer has explicitly stated does not appear to meet admission criteria at this time.

23 HOUR OBSERVATION STAY

This is not a level of care that requires prior authorization but is a level of care that is separate and distinct from psychiatric inpatient level of care.

I. DEFINITION OF SERVICE:

A 23 Hour Observation Stay occurs in a secure, medically staffed, psychiatrically supervised facility. This level of care, like acute inpatient hospitalization, involves the highest level of skilled psychiatric services. This service can be rendered in a psychiatric unit of a general hospital, or in the emergency department of a licensed hospital. The care must be provided under the direction of an attending physician who has performed a face-to-face evaluation of the member. The care involves an individual treatment plan that includes access to the full spectrum of psychiatric services. A 23 Hour Observation Stay provides an opportunity to evaluate members whose needed level of care is not readily apparent. In addition, it may be used to stabilize a member in crisis, when it is anticipated that the member's symptoms will resolve in less than 24 hours.

This level of care may be considered when support systems and/or a previously developed crisis plan have not sufficiently succeeded in stabilizing the member, and the likelihood for further deterioration is high. This level of care is available for all age ranges.

If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

The following are exemptions to the general observation stay definition:

a. The eligible recipient dies;
b. Documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by his legal guardian against medical advice;
c. An eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or
d. An inpatient admission results in delivery of a child.

If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

A hospital must bill these services as outpatient observation services.

Outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

The hospital or attending physician can request a re-review and reconsideration of the observation stay decision.

The observation stay review does not replace the review of one- and two-day stays for medical necessity.

Medically unnecessary admissions, regardless of length of stay, are not covered benefits.

II. ADMISSION CRITERIA (MEETS A AND B, AND C OR D OR E):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention in less than 24 hours in a secure setting.

B. The member cannot be evaluated in a less restrictive level of care.

C. The member is expressing suicidal ideation or is expressing threats of harm to others that must be evaluated on a continuous basis for severity and lethality.

D. The member has acted in disruptive, dangerous or bizarre ways that require further immediate observation and assessment. An evaluation of the etiology of such behaviors is needed, especially if suspected to be chemically or organically induced.

E. The member presents with significant disturbances of emotions or thought processes that interfere with his/her judgment or behavior that could seriously endanger the member or others if not evaluated and stabilized on an emergency basis.

III. DISCHARGE CRITERIA (MEETS BOTH):

A. The member no longer meets admission criteria.

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

IV. EXCLUSIONARY CRITERIA (MAY MEET ANY):

A. The member meets admission criteria for Acute Inpatient Hospitalization.

B. The member appears to have presented for admission for reasons other than a primary psychiatric emergency, such as homelessness or inappropriate seeking of medications.

ACCREDITED RESIDENTIAL TREATMENT

I. DEFINITION OF SERVICE:

Accredited Residential Treatment Center Services (ARTC) is a service provided to members under the age of 21 whom, because of the severity or complexity of their behavioral health needs. These are members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others. ARTC facilities must be licensed by the New Mexico Department of Children Youth & Families Licensing and Credentialing Authority (or similar body when located in other states). The need for ARTC services must be identified in the tot to teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

ARTC services are provided in a 24-hour a day/7 days a week accredited (Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all diagnostic and therapeutic services provided. ARTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on a member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

For more detailed information please reference NMAC 8.321.2.11.

II. ADMISSION CRITERIA (MEETS ALL):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.

B. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well being of the member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral

health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.

C. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria including the need for 24 hour staff supervision.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.

C. The treatment and therapeutic goals are objective, measurable and time-limited to address the alleviation of psychiatric symptoms and precipitating psychosocial stressors.

D. An individualized discharge plan has been developed/updated which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

E. The member is actively participating in treatment and is motivated and engaged.

F. The member's parent(s), guardian or custodian is participating in the treatment and discharge planning. If parent(s), guardian or custodian are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning.

G. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

IV. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her individualized discharge criteria.

B. The member can be safely treated at a less intensive/restrictive level of care.

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

V. EXCLUSIONARY CRITERIA FOR ARTC (MAY MEET ANY):

A. There is evidence (documented) that the ARTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.

B. There is evidence that the ARTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a

parent or guardian to receive the member back into the home is not grounds for continued ARTC care.

C. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

D. Quality of Service Criteria #5 and/or #8 are not met.

SUB-ACUTE RESIDENTIAL TREATMENT

Not a Value Added Service and is only available to providers contracted specifically to provide this service.

I. DEFINITION OF SERVICE:

Sub Acute RTC is provided to members under the age of 21 who, because of the severity or complexity of their behavioral health needs, and who require services beyond the scope of the usual Residential Treatment Center Services (RTC) milieu or other out-of-home or community-based treatment services. These are members who, as a result of a recognized psychiatric disorder(s) are a significant danger to themselves or others, but not so acute as to be in need of inpatient hospitalization. Sub Acute RTC facilities must be licensed by the New Mexico Department of Children Youth & Families Licensing and Credentialing Authority (or similar body when located in other states). The need for RTC services must be identified in the tot to teen Healthcheck or other diagnostic evaluation furnished through a Healthcheck referral and the member must meet medical necessity criteria as part of early and periodic screening, diagnosis and treatment (EPSDT) services [42 CFR Section 441.57].

Sub Acute RTC services are provided in a 24-hour a day/7 days a week accredited (Joint Commission, http://www.jointcommission.org/) facility. Facilities provide all the diagnostic and therapeutic services provided by an RTC, **but with a higher staff to client ratio**. Sub Acute RTC units are medically staffed at all times with direct psychiatric services provided several days a week and with 24-hour psychiatric consultation availability. The services are provided under the direction of an attending psychiatrist. The treatment plan is reviewed frequently and updated based on member's clinical status. Regular family therapy is a key element of treatment and is required except when clinically contraindicated. Discharge planning should begin at admission, including plans for successful reintegration into the home, school and community. If discharge to a home/family may not be a realistic option, alternative placement/housing must be identified as soon as possible and documentation of active efforts to secure such placement must be thorough.

This service should not be authorized solely as a substitute for management within the juvenile justice or protective services systems, as an alternative to specialized schooling (which should be provided by the local school system) or simply to serve

as respite or housing. Academic schooling funded through the local school system or by the facility is expected.

For more detailed information please reference NMAC 8.321.2.11.

II. ADMISSION CRITERIA (MEETS ALL):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.302.1.7 and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.

B. The member is experiencing emotional or behavioral problems in the home and/or community to such an extent that the safety or well being of the member or others is substantially at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that inpatient hospitalization may be required if the individual is not treated at this level of care.

C. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria including 24 hour staff supervision.

B. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Sub-Acute RTC treatment has been developed implemented and updated, with the member's or guardian's participation, whenever possible. The treatment plan includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.

D. An individualized discharge plan has been developed/updated which 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.

E. The member is participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the member's engagement in treatment.

The member's parent(s), guardian or custodian is participating in the treatment and discharge planning, or persistent efforts are being made and documented to involve them, unless it is clinically contraindicated.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.

B. The member has not benefited from Sub Acute Residential Treatment Center Services despite documented persistent efforts to engage the member.

C. The member can be safely treated at a less intensive/restrictive level of care.

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

V. EXCLUSIONARY CRITERIA FOR SUB-ACUTE RTC (MAY MEET ANY):

A. There is evidence (documented) that the Sub Acute RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met. There is evidence that the Sub Acute RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Sub Acute RTC care. This is all part of 1.

B. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

C. Quality of Service Criteria # 5: *The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.*

D. Quality of Service Criteria #8: *Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.*

NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS

I. DEFINITION OF SERVICE:

Non-Accredited Residential Treatment Center services are provided to members under the age of 21 years who require 24-hour treatment and supervision in a safe therapeutic environment.

For more detailed information please refer to NMAC 8.321.2.20.

II. ADMISSION CRITERIA (MEETS ALL):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.

B. The member is experiencing emotional or behavioral problems in the home, community and/or treatment setting to such an extent that the safety or well-being of the member or others is at risk. These problems require a supervised, structured, and 24-hour continuous therapeutic milieu in a residential setting.

C. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.

D. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria including the need for 24 hour staff supervision.

B. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required residential treatment has been developed, implemented and updated, with the member's or guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited

C. The current or revised treatment plan can be reasonable expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.

D. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care within the member's community. A timeline for expected implementation and completion is in place but discharge criteria have not yet been, or other barriers to discharge exist which the provider has made reasonable efforts to mitigate.

E. The member is actively participating in treatment and is motivated and engaged in active efforts to lead to the member's discharge plan.

F. The member's parent(s), guardian or custodian is participating in treatment and discharge planning. If parent(s), guardian or custodian care are not involved, alternative natural supports need to be identified to engage in treatment and discharge planning. Criteria for this is weekly involvement in family therapy, treatment planning and discharge planning.

G. Member is making progress in the treatment program. Goals are realistic, targeted, time-limited, and achievable.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.

B. The member has not realized substantial benefit from Residential Treatment Services despite documented persistent efforts to engage the member.

C. The member can be safely treated at a less intensive/restrictive level of care.

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

V. EXCLUSIONARY CRITERIA FOR RTC (MAY MEET ANY):

A. There is evidence that the RTC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.

B. There is evidence that the RTC treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued RTC care.

C. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

D. The member's current condition cannot be effectively and safely treated in a lower level of care even when the treatment plan is modified, attempts to enhance the member's motivation have been made, or referrals to community resources or peer supports have been made.

E. Treatment is not primarily for the purpose of providing respite for the family, increasing the member's social activity, or for addressing antisocial behavior or legal problems, but is for the active treatment of a behavioral health condition.

TREATMENT FOSTER CARE I AND II

I. DEFINITION OF SERVICE:

Treatment Foster Care (TFC), is a behavioral health service provided to members under the age of 21 years who are placed in a 24-hour community-based supervised, trained, surrogate family through a TFC placement agency licensed by the New Mexico Department of Children Youth & Families Licensing and Credentialing Authority.

For more details please refer to NMAC 8.321.2.25 and NMAC 8.321.2.26.

II. ADMISSION CRITERIA (Meets A, B, E, and C or D):

**These admission criteria are for both TFC I and II, with some caveats, as noted below.*

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic interventions implemented in a TFC/family living experience treatment setting.

B. The member's current (within 30 days of proposed admission) medical and psychiatric symptoms require and can be managed safely in a 24-hour supervised community/home-based setting.

C. The member is immediately at risk for needing a higher level of services and/or being excluded from community, home or school activities due to clinically significant disruptive symptoms or behaviors. These symptoms or behaviors are not amenable to treatment in the member's own home or a standard foster care environment.

D. A licensed behavioral health professional has made the assessment that the member is likely to experience a deterioration of his/her condition to the point that a more restrictive treatment setting may be required if the individual is not treated at this level of care at this time.

E. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

FOR <u>TFC I</u> THE FOLLOWING ADDITIONAL ADMISSION CRITERIA MUST BE MET:

F. The member is unable to participate independently (without 24-hour adult supervision) in age appropriate activities.

FOR <u>TFC II</u> THE FOLLOWING ADDITIONAL ADMISSION CRITERIA MUST BE MET:

G. The member has met the treatment goals of TFC I or is able to participate independently in age appropriate activities without 24-hour adult supervision.

Additionally, to be appropriate for TFC II, the member's treatment needs or social, behavioral, emotional, or functional impairments are not as serious or severe as those exhibited by members who meet criteria for TFC I; therefore, services are less clinically intensive than those provided in TFC I. Members in TFC II can generally participate independently in age appropriate activities (e.g. dressing self at age 7, working at age 16, attending school without parental classroom supervision), while members in TFC I could require supervision for those activities. TFC II is often, but not always, used as a transition from TFC I; members may be admitted directly to TFC II. Conversely, <u>not all members in TFC I need to go to TFC II before discharge from TFC.</u>

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet all relevant admission criteria.

B. The member continues to need 24-hour adult supervision and/or assistance to develop, restore or maintain skills and behaviors that are necessary to live safely in their own home and community.

C. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required TFC treatment has been developed, implemented and updated according to licensing rules, with the member's and/or legal guardian's participation, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.

E. An individualized discharge plan has been developed (and updated since the last clinical review/approval) which 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.

F. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.

G. The parent, legal guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

IV. CRITERIA FOR TRANSITION FROM TFC I TO TFC II (MEETS ALL):

A. A review of the individualized treatment and permanency plan shows that the member has met a significant portion of all TFC I treatment goals.

B. Continued stay in a treatment foster care setting is necessary to maintain the gains made in TFC I, but member does not require the intensity of supervision associated with TFC I.

C. The member is able to participate independently in age appropriate activities without continuous adult supervision.

V. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.

B. The member has not benefited from Treatment Foster Care despite documented persistent efforts to engage the member.

C. The member can be safely treated at a less intensive level of care.

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

VI. EXCLUSIONARY CRITERIA FOR TFC I AND TFC II (MAY MEET ANY):

A. There is evidence that the TFC placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.

B. There is evidence that the TFC treatment episode is intended to defer or prolong a permanency plan determination or is substituting for permanent housing.

C. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

GROUP HOME

I. DEFINITION OF SERVICE:

Group Home is a lower level of care than Residential Treatment Center Services and is indicated when a structured home-based living situation is unavailable or not clinically appropriate for the member's behavioral health needs and the member needs services focused on psychosocial skills development. Group Home services also differ from Treatment Foster Care in that they are residentially and group based, rather than family and community based.

For more details please refer to 8.321.2.20.

II. ADMISSION CRITERIA (MEETS A, B AND C, AND EITHER D OR E):

A. Medical necessity has been demonstrated according to the New Mexico Medical Assistance Division definition contained in NMAC 8.305.1, and the member has a DSM diagnosed condition that requires, and is likely to benefit from, therapeutic intervention.

B. The member may manifest significant psychological or behavioral disturbances but can participate in age-appropriate community based activities (including school) with assistance from group home staff or with other support.

C. Less restrictive or intensive levels of treatment have been tried and shown to be inadequate to meet the member's needs. Documentation exists to support these contentions.

D. A structured home-based living situation is unavailable or is not appropriate for the member's needs.

E. The member is in need of 24-hour therapeutic milieu but does not require the intensive staff assistance that is provided in Residential Treatment Center Services.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. The member continues to meet admission criteria.

B. The member continues to need 24-hour supervision and assistance to develop or restore skills and behaviors that are necessary to live safely in the home and community.

C. An individualized treatment plan that addresses the member's specific symptoms and behaviors that required Group Home treatment has been developed, implemented and updated, with the member's and/or guardian's participation whenever possible, which includes consideration of all applicable and appropriate treatment modalities. The treatment and therapeutic goals are objective, measurable and time-limited.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvements or progress to address the goals of treatment. Progress is documented toward treatment goals.

E. An individualized discharge plan has been developed which 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.

F. The member is participating in treatment, or there are active, persistent efforts being made that can reasonably be expected to lead to the member's engagement in treatment.

G. The parent, guardian or custodian is participating in the treatment, discharge and/or permanency planning, or persistent efforts are being made and documented to involve them, unless it is clinically indicated otherwise.

IV. DISCHARGE CRITERIA (MEETS A OR B, AND C AND D):

A. The member has met his/her individualized discharge criteria.

B. The member has not benefited from Group Home services despite documented persistent efforts to engage the member.

C. The member can be safely treated at a less intensive level of care
D. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

V. EXCLUSIONARY CRITERIA (MAY MEET ANY):

A. There is evidence that the Group Home placement is intended as an alternative to incarceration or community corrections involvement, and medical necessity have not been met.
B. There is evidence that the Group Home treatment episode is intended to defer or prolong a permanency plan determination. The inability or unwillingness of a parent or guardian to receive the member back into the home is not grounds for continued Group Home care.
C. The individual demonstrates a clinically significant level of institutional dependence and/or detachment from their community of origin.

APPLIED BEHAVIORAL ANALYSIS (ABA) - STAGE 3 AND SPECIALTY CARE PROVIDERS

ABA services are provided to a Medical Assistance Programs (MAP) eligible member 12 months up to 21 years of age. A member's eligibility for ABA service falls into one of two categories: "At Risk for ASD" or "Diagnosed with ASD." An eligible member must meet the level of care (LOC) criteria detailed below, which includes medically necessary criteria, and the requirements which have been detailed in the Medical Assistance Program Manual Supplement 16-08.

For more detailed information please reference NMAC 8.321.2.

I. ADMISSION CRITERIA for Diagnosed with ASD and At-Risk for ASD: *(Must meet A-G for admission)*

- **A.** Services are determined to be medically necessary per NMAC 8.302.1.7. and the Medical Assistance Program Manual Supplement 16-08.
- **B.** The eligible member cannot adequately participate in home, school, or community activities because the presence of behavioral excesses (i.e. socially significant behaviors) and/or the absence of functional skills interfere with meaningful participation in these activities; and/or
- **C.** The eligible member presents a safety risk to self or others. (The presence of safety risk to self or others does not need to meet the threshold criteria for out-of-home placement.)
- **D.** There is a reasonable expectation that ABA services will result in measurable improvement in the acquisition of functional, adaptive skills, and/or the reduction of non-functional, maladaptive behavior.
- **E.** The eligible member's caregivers are able to participate and commit meaningfully to ABA interventions and activities to be conducted outside the formal treatment environment.
- **F.** The eligible member follows the prescribed three-stage comprehensive approach to evaluation, assessment, and treatment as outlined in the MAD ABA Billing Instructions and the Medical Assistance Program Manual Supplement 16-08.
- **G.** The eligible member meets one of the following two categories:
    1. *At-risk for ASD*: An eligible member may be considered At-Risk for ASD, and therefore eligible for time-limited, Focused ABA Services if he or she does not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when he or she meets all of the following criteria:
        a) Is between 12 and 36 months of age;
        b) Presents with developmental differences and/or delays as measured by standardized assessment;

c) Demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior);
d) Presents with at least one genetic risk factor (e.g., the eligible member has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD; the eligible member has a diagnosis of Fragile X syndrome).

2. *Diagnosed with ASD:* An eligible member 12 months up to 21 years of age who has a medical diagnosis of ASD according to the latest DSM or ICD criteria is eligible for ABA services if the evaluation leading up to a diagnosis of ASD meets service requirements as stated in NMAC 8.321.2 (10.C*) Covered services - stage 1* and the Medical Assistance Program Manual Supplement 16-08.
   a) When a member has been diagnosed with ASD within the last 12 months by an in-state or out-of-state provider who meets Stage 1 provider requirements, an ICD may be developed.

II. CONTINUED ELIGIBILITY CRITERIA:

(Must meet A THROUGH C, OR BOTH A AND D for continuation)

A. The eligible member continues to meet the ABA admission criteria.

B. There is evidence the child, family, and social supports can continue to participate effectively in this service.

C. The eligible member responds positively to ABA services, as evidenced by quantitative data submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services.

D. When the eligible member does not respond positively to ABA services, as evidenced by quantitative data and clinical information submitted by the ABA Provider (AP) when requesting prior authorization for continuation of ABA services, the treatment plan and the treatment plan report (i.e., graphs, peer review) must be updated to reflect what interventions will be changed to produce measurable gains.

III. DISCHARGE CRITERIA:

(Must meet one of A-D for discharge)

Individualized discharge criteria are developed with appropriate, realistic, and timely follow-up care and these criteria are included in the initial or most current ABA Treatment Plan. An eligible member may be discharged from ABA services when any of the following are present:

A. The eligible member has met his or her individualized discharge criteria.

B. The eligible member has reached the defining age limit as specified for At-Risk for ASD eligibility which is up to 3 years of age, or for Diagnosed with ASD eligibility which is under 21 years of age.

C. The eligible member can be appropriately treated at a less intensive level of care.

D. The eligible member requires a higher level of care, which includes out-of-home placement.

Note: Out-of-home placement would not include treatment foster care because ABA services could continue at that level of care.

IV. EXCLUSIONARY CRITERIA:

(Must meet one of A-F for exclusion)

An eligible member may be excluded from ABA services when any of the following are present:

A. The eligible member's Comprehensive or Targeted Diagnostic Evaluation or the ISP and/or Treatment Plan Updates recommend placement in a higher, more intensive, or more restrictive LOC (Not to include treatment foster care: See note in Section III.).

B. The eligible member's provider, such as psychiatrist, recommends higher LOC.

C. The eligible member is in an out-of-home placement (Not to include treatment foster care: See note in Section III).

- An exception is that time limited ABA services may be authorized while the member remains in the out-of-home facility for transition when ABA services are approved to be rendered upon his or her discharge from the facility to a community ABA provider.

D. The referral for the Comprehensive Diagnostic Evaluation did not follow the Eligibility requirements defined in 8.321.2 Section 10(B).

E. The member has reached the maximum age for ABA services.

F. Family/caregiver is unable to participate in the treatment plan.

BEHAVIORAL HEALTH RESPITE

I. DEFINITION OF SERVICE:

As part of centennial care's comprehensive service system, behavioral health (BH) respite service is for short-term direct care and supervision of the eligible recipient to afford the parent(s) or caregiver a respite for their care of the recipient and takes place in the recipient's home or another setting. BH respite services may include a range of activities to meet the social, emotional and physical needs identified through the service or treatment plan and documented in the treatment record. These services may be provided for a few hours during the day or for longer periods of time involving overnight stays. BH respite, while usually planned, can also be provided in an emergency or unplanned basis.

Prior Authorization: 30 days or 720 hours per year are covered without prior authorization, at which time prior authorization must be acquired for additional respite care.

For more detailed information please reference BH Supplement 19-04.

II. ADMISSION CRITERIA (MEETS A or B and C & D):

A. Members up to 21 years of age diagnosed with a severe emotional disturbance (SED), as defined by the state of New Mexico who reside with the same primary caregivers daily; or
B. Youth in protective services custody whose placement may be at risk.
C. Outpatient services alone will not meet the family's or caregiver's needs for support and education.
D. Family and caregivers are unable to participate in the normal activities of daily life in the community as a result of caring for the enrollee, thus putting the enrollee at risk for out-of-home service level beyond the scope of Respite Care.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. Member's condition continues to meet admission criteria and has not been admitted to a higher level of care.
B. Evidence of interdisciplinary team meeting is occurring monthly to ensure that continued stay criteria is being reviewed. Member's MCO and/or Medicaid Care Coordinator should be invited to participate.

IV. DISCHARGE CRITERIA (MEETS ALL):

A. The member has met his/her individualized discharge criteria.
B. The member can be safely treated at a less intensive level of care.
C. An individualized discharge plan with appropriate, realistic and timely follow-up care has been formulated.

V. EXCLUSIONARY CRITERIA (MAY MEET ANY):

A. Member meets the criteria for a more or less intensive and restrictive level of care.
B. Member has medical condition(s) that prevents utilization of Respite care
C. This service may not be billed in conjunction with TFC, Group Home Residential Services, or Inpatient Treatment.
D. Respite should not be used as a substitute for permanent housing or childcare.

ELECTROCONVULSIVE THERAPY (ECT)

ECT is a benefit for the Alternative Benefit Plan (Medicaid Expansion Population) and is a Value Added (non-entitlement) Service for standard Medicaid recipients.

I. DEFINITION OF SERVICE:

Electroconvulsive therapy (ECT) is a beneficial treatment for certain disorders and is usually administered in an inpatient or outpatient facility that provides both psychiatric and anesthesiology services. ECT should be considered when a Member has severe or treatment resistant depression, psychotic disorders, or

prolonged or severe mania. In addition, ECT may be indicated when there is a history of a positive response to ECT, a contraindication to standard psychotropic medication treatments, or when there is an urgent need for response, such as severe suicidality or food refusal leading to nutritional compromise. A valid consent must be obtained for ECT; if the Member is not competent to refuse or consent to the procedure, then a treatment guardian should be obtained. The person giving consent should be informed of the risks and benefits of ECT along with alternative treatments considered, and the record should document that the Member or guardian clearly understands these elements of the consent. These criteria will be used to authorize the procedure of ECT. Authorization for this procedure does not imply authorization for a particular level of care.

II. CRITERIA FOR APPROVAL (MEETS ALL):

- **A.** Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the Member has a DSM diagnosed condition that requires and is likely to benefit from the proposed therapeutic intervention.
- **B.** A second opinion from a psychiatrist confirms that ECT is an appropriate treatment for the Member.
- **C.** A medical evaluation indicates no contraindication for ECT.
- **D.** Informed consent for ECT has been obtained and documented in the treatment record.
- **E.** The Member has been diagnosed with major depression, Mania, Catatonia, and Certain acute schizophrenic exacerbations.
- **F.** Member is unresponsive to effective medications (adequate dose and duration) that are indicated for the Member's condition or Member is unable to tolerate effective medications or has a medical condition for which medication is contraindicated, or Member has had favorable response to ECT in the past, or Member is unable to safely wait until medication is effective, due to inanition (a condition characterized by marked weakness, extreme weight loss, and a decrease in metabolism resulting from prolonged and severe insufficiency of food), stupor, extreme agitation, high suicide or homicide risk, etc.

III. CRITERIA FOR MAINTENANCE ELECTROCONVULSIVE THERAPY (MEETS ALL):

- **A.** The Member meets the criteria for approval for ECT as outlined above, received ECT, and had a documented positive response.
- **B.** Other treatment options are not viable for the Member.
- **C.** A second opinion from another (other than the current treating psychiatrist) is obtained every 9 months documenting the need for maintenance ECT.

IV. EXCLUSIONARY CRITERIA (MAY MEET ANY):

- **A.** ECT shall not be performed on a child, except by order of a court upon a finding that the treatment is necessary to prevent serious harm to the child (NM Statute 32A-6-14). The clinical criteria noted above must also be met.

B. Electroconvulsive therapy (ECT) is considered experimental, investigational, and/or unproven for all other indications not noted above.

C. Multiple monitored electroconvulsive therapy (MMECT) is considered experimental, investigational and/or unproven.

PARTIAL HOSPITALIZATION, PSYCHIATRIC, ADULT, ADOLESCENT & CHILD

I. DEFINITION OF SERVICE:

Partial Hospitalization Program (PHPs) is structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinical services. PHP can be provided in acute care or freestanding psychiatric hospital. The need for outpatient or partial hospitalization services must be identified in a diagnostic evaluation. To help Centennial Care recipients under 21 years of age receive the level of services needed, Centennial Care pays for partial hospitalization services furnished in acute care or freestanding psychiatric hospital as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services [42 CFR Section 441.57]. The need for outpatient or partial hospitalization services must be identified in the Tot to Teen Healthcheck screen or other diagnostic evaluation furnished through a Healthcheck referral.

Partial Hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised, treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services, as would be provided in an inpatient setting, except that the recipient is in the program less than 24 hours a day and it is a time limited program. Partial Hospitalization is designed for Members with serious behavioral disorders or disturbances of community functioning that require an intensive, ambulatory and active treatment program. The Member can be maintained safely in the community but requires close monitoring. Support systems should be available and willing to assist the Member with participation in treatment whenever possible. Partial Hospitalization offers intensive, multi-modal structured clinical services within a stable therapeutic milieu setting. Appropriate staff is available on a 24 hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the Member, make referrals as necessary, and provide follow up. An individualized treatment plan is developed, reviewed and updated on a regular basis. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should include caretakers‘/guardians‘/family Members’ involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the Member to a lesser level of care. Partial Hospitalization programs may vary considerably depending upon the age and severity of illness of the Members for whom the program is designed. Partial Hospitalization programs shall offer at least 20 hours per week of skilled treatment services.

This level of care is available for all age ranges, but admission should be to a program that is age appropriate. For school age Members, elementary and secondary schooling provided through the local school system or by the facility is expected.

II. ADMISSION CRITERIA (MEETS ALL):

A. Medical necessity has been demonstrated according to NMAC 8.302.1.7 and the Member has a DSM diagnosed condition that requires, and is likely to benefit from the proposed therapeutic intervention. Presence of the illness(es) must be documented through the assignment of appropriate DSM diagnosis.

B. There is clinical evidence that the Member's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly psychiatric nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay. The individualized plan of treatment includes a structured **program with evaluation by a psychiatrist within 48 hours.**

C. Either:

1. There is clinical evidence that the Member would be at risk to self or others if he or she were not in a partial hospitalization program, or
2. As a result of the Member's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family Members are unable to safely fulfill these needs, representing potential serious harm to self.

D. Additionally; either:

1. The Member can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, or
2. The Member is believed to be capable of controlling unsafe behavior and/or seeking professional assistance or other support when not in the partial hospital setting.

E. The Member is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

F. For Members over 60 years of age, assessment of cognitive functioning is warranted with standardized screening tools for cognitive assessment.

III. CONTINUED STAY CRITERIA (MEETS ALL):

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria or
2. The emergence of additional problems that meet the admission criteria or
3. That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the

psychiatric illness to the degree that would necessitate continued partial hospitalization treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the Member's post-partial hospitalization needs. A Urine Drug Screen (UDS) should be considered when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider should be considered.

C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-partial hospitalization treatment resources.

E. All applicable elements in admission are applied as related to assessment and treatment, if clinically relevant and appropriate.

PARTIAL HOSPITALIZATION, SUBSTANCE USE DISORDERS - ADULTS

- PLEASE REFER TO 2.5 PARTIAL HOSPITALIZATION SERVICES ADULTS - ASAM CRITERIA 3RD EDITION – 2013.

PARTIAL HOSPITALIZATION, SUBSTANCE USE DISORDERS – ADOLESCENTS

- PLEASE REFER TO 2.5 PARTIAL HOSPITALIZATION SERVICES ADOLESCENT- ASAM CRITERIA 3RD EDITION – 2013.