Beacon Health Strategies, LLC. / New York Level of Care Criteria

Level of Care Criteria

Beacon's Level of Care (LOC) criteria were developed from the comparison of national, scientific and evidence based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon's LOC criteria, are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice.

Members must meet medical necessity criteria for a particular LOC of care. Medically necessary services are those which are:

A. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM-,) that threatens life, causes pain or suffering, or results in illness or infirmity.
B. Expected to improve an individual's condition or level of functioning.
C. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
D. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
E. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
F. Not primarily intended for the convenience of the recipient, caretaker, or provider.
G. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
H. Not a substitute for non-treatment services addressing environmental factors.

Beacon uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. Beacon's LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

In addition to meeting Level of Care Criteria; services must be included in the member's benefit to be considered for coverage.

Section I: Inpatient Behavioral Health

Overview

This chapter contains information on LOC criteria and service descriptions for inpatient behavioral health (BH) treatment including:

A. Acute Inpatient Psychiatric Treatment

Beacon's inpatient service rates are all inclusive with the **single exception** of electro-convulsive therapy (ECT). Routine medical care is also included in the per diem rate for inpatient treatment. **Any medical care above and beyond routine must be reported to Beacon for coordination of benefits with the health plan.**

A. Acute Inpatient Psychiatric Services

Acute inpatient psychiatric service is the most intensive level of psychiatric treatment, and it is used to stabilize individuals with an acute worsening, destabilization, or sudden onset psychiatric condition of short, severe duration. A structured treatment milieu and 24-hour medical and skilled nursing care is fundamental to inpatient treatment. Daily contact between the member and physician is required. Behavioral health providers may also have physical and mechanical restraint, isolation and locked units available as additional resources.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria # 1 - 4 must be met; For Eating Disorders, # 5 or 6 must also be met: 1. DSM or corresponding ICD diagnosis is present. 2. Member's psychiatric condition must require 24-hour medical/psychiatric and nursing services and/or must be of such intensity that needed services can only be provided by acute hospital care. 3. Inpatient services in an acute care hospital must be expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed. 4. One of the following must also be present: a. Indication of actual and/or potential danger to self or others, such as serious suicidal ideation with plan and means available especially with a history of prior suicide attempts; b. History of suicidal ideation accompanied by severely depressed mood, significant losses and/or continuing intent to hurt self or others; c. Command hallucinations; d. Persecutory delusions; e. Documented history of violence; f. Loss of impulse control resulting in life threatening behavior, significant weight loss within the past three months, or self mutilation that could lead to permanent disability; g. Homicidal ideation with indication of actual or potential danger to others; h. Indication of actual or potential danger to property evidenced by documented recent history of threats of violent or dangerous	**Criteria #1 - 6 must be met; For Eating Disorders, criterion #7 must be met:** 1. Member continues to meet admission criteria and another level of care (LOC) is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, s/he would likely need re-hospitalization; 3. Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Family/guardian/caregiver is participating in treatment where appropriate, with documentation around coordination of treatment and with state agencies or other community agencies, if involved. 6. Coordination of care and active discharge planning are ongoing,	**Criteria #1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional. For Eating Disorders, criteria #7 - 9 must be met:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment *and* member does not meet criteria for involuntary/ mandated treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support system is aware and in agreement with the aftercare treatment plan. **For Eating Disorders:** 7. Member has reached at least 75% healthy body weight and has gained

Admission Criteria	Continued Stay Criteria	Discharge Criteria
and destructive acts that may injure self or others; i. Individual is impaired on the basis of their primary psychiatric illness to the degree that s/he manifests major disability in social, interpersonal, occupational and/or educational functioning and is not responsive to treatment and/or management efforts at a less intensive level of care; j. Individual has substance use disorder/dependence and need for treatment and services to ensure sobriety during stabilization of psychiatric condition; or k. Evidence of severe disorders of cognition, memory, or judgment not associated with a primary diagnosis of dementia or other cognitive disorder and family/community support cannot be relied upon to provide essential care. **For Eating Disorders:*** 5. Member has psychiatric, behavioral and general medical factors (such as a rapid or persistent decline in oral intake and significant decline in weight). 6. Member has had a rapid life threatening volitional weight (i.e. not thought to be the result of medical illness loss (Body Mass Index < 16) or below 75% of estimated healthy body weight that required treatment in an acute medical setting for one of the following: a. Marked physiological lability, e.g. significant postural hypotension, bradycardia, CHF, cardiac arrhythmia; b. Change in mental status; c. Body temperature below 96 degrees; d. Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement; e. Acute gastrointestinal dysfunction such as esophageal tear from vomiting, mega colon or colonic damage from self-administered enemas; or f. Member has been uncooperative with treatment and/or is only able to cooperative in a highly structured, controlled setting that can provide one or all of the following: • Needed supervision during and after meals and/or required special feeding • Needed supervision during and after all meals and during use of bathroom **Exception to the above criteria may be made for early intervention with newly diagnosed adolescent anorexic admission requests.*	with goal of transitioning the member to a less intensive LOC. **For Eating Disorders**: 7. No appreciable weight gain (<2lbs/wk) and/or unstable medical sequelae or refeeding complication.	enough weight to achieve medical stability (e. g., vital signs, electrolytes, and electrocardiogram are stable). 8. No re-feeding is necessary 9. All other psychiatric disorders are stable.

B. Inpatient Substance Use Disorder Services - Medically Managed (Level IV Detoxification)- (See ASAM Level 4 Criteria)

C. Acute Substance Use Disorders Treatment – Medically Monitored (Level III Detoxification)- See ASAM Level 4 Criteria or ASAM level 3.7 Criteria for Hudson)

D. Inpatient Acute Substance Disorder Rehabilitation (IP Rehab)- See ASAM Level 3.5 Criteria

SECTION II: DIVERSIONARY SERVICES

Overview

Diversionary services are those mental health and substance use treatment services that are provided as clinically appropriate alternatives to behavioral health inpatient services, or to support a member in returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.

This chapter contains service descriptions and level of care criteria for the following non-24-hour, diversionary services specifically designed to provide a continuum between inpatient and outpatient levels of care, including:

A. **Acute Partial Hospital Programs (PHP)**
B. **Intensive Outpatient Programs (IOP) (For SA LOC See ASAM Criteria Level 2.1)**
C. **Day Treatment**
D. **Continuing Day Treatment**
E. **Personalized Recovery Orientated Services (PROS)**
F. **Psychosocial Rehab (PSR)**
G. **Intensive Psychiatric Rehabilitation Treatment (IPRT)**
H. **Community Psychiatric Support and Treatment (CPST)**

A. Acute Partial Hospital Programs (PHP)

Acute Partial Hospital Programs are short-term day programs consisting of intensive, acute treatment within a stable therapeutic milieu. These programs must be available at least five days per week, although seven-day availability is preferable. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires daily psychiatric management and active treatment comparable to that provided in an inpatient setting. Length of stay generally ranges between two days to two weeks, and declines in intensity or frequency as an adult member establishes community supports and resumes normal daily activities or as a child or adolescent member returns to reliance on family, community supports and school. A PHP may be provided by either hospital-based or freestanding facilities for members experiencing symptoms of such intensity that they are unable to be safely treated in a less intense setting and would otherwise require admission to an inpatient level of care (LOC).

For children and adolescents who have a supportive environment to return to in the evening, a PHP provides services similar to a hospital level of care. As the youth decreases participation and returns to reliance on community supports and school, the PHP consults with the caretakers and the child's programs as needed to implement behavior plans, or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1 - 8 must be met; For Eating Disorders, criterion #9 must also be met: 1. DSM or corresponding ICD diagnosis. 2. Member manifests significant or profound impairment in daily functioning due to psychiatric illness. 3. Member has adequate behavioral control and is assessed not to be an immediate danger to self or others and does not require 24-hour medical supervision. 4. Member has a community-based network of support and/or parents or caretakers who are able to ensure member's safety outside the treatment hours. 5. The member requires access to a structured treatment program with an on-site multidisciplinary team. 6. Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize their condition. 7. The severity of the presenting symptoms is such that the member is unable to be treated safely or adequately in a less intense outpatient setting. 8. Member has fair to good motivation to recover in	**Criteria # 1 - 6 must be met; For Eating Disorders, criterion # 7 must also be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Treatment is still necessary to reduce symptoms and increase functioning, so the member may be treated in a less intensive LOC. 3. Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 6. Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive	**Criteria 1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional; For Eating Disorders, criterion # 7 must also be met:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support systems are in agreement with the aftercare treatment plan. **For Eating Disorders**: 7. Member has been compliant with the Eating Disorder related protocols and can now be managed in a less intensive

Admission Criteria	Continued Stay Criteria	Discharge Criteria
the structure of the ambulatory treatment program. **For Eating Disorders:** 9. Member requires admission to achieve at least one of the following: a. Stabilize weight and/or accomplish targeted weight gain; b. Reduction in compulsive exercising or repetitive behaviors that negatively impact daily functioning.	LOC. **For Eating Disorders:** 7. Member has had no appreciable weight gain since admission.	LOC.

B. Intensive Outpatient Programs (IOP) (For SA LOC See ASAM Criteria Level 2.1)

Intensive Outpatient Programs (IOP) are similar to Partial Hospital Programs (PHP), offering short-term day or evening programming consisting of intensive treatment within a stable therapeutic milieu. These programs must be available at least five days per week, although seven-day availability is preferable. Participation should be a minimum of 3 times per week, increasing based on clinical need. Briefly tapering to fewer than 3 times per week while transitioning to less intensive services is appropriate when clinically indicated. IOPs are required to provide daily management and active treatment comparable to that provided by a Partial Hospital Program setting. Length of stay generally ranges from 1 to 3 weeks, declining in intensity as the member establishes community supports and resumes normal daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long-term day treatment. IOPs may be provided by either hospital-based or freestanding outpatient programs to members who are experiencing symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive level of care (LOC), e.g., PHP.

For youth, the IOP provides services similar to an acute LOC for those who have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child's caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis (excluding mental retardation or other developmental disorder diagnosis). 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3. Treatment is still necessary to reduce symptoms and	**Criteria # 1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive.

functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a routine outpatient LOC. 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IOP treatment. 5. Member’s living environment offers enough stability to support IOP treatment. 6. Member’s biomedical condition and/or co-morbid substance use disorder is sufficiently stable to be managed in an outpatient setting.	improve functioning so the member may be treated at a less intensive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 6. Family/guardian/caregiver is participating in treatment as appropriate. Documentation reflects coordination of treatment with all involved parties including state and/or community agencies when appropriate.	2. Member or guardian withdraws consent for treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member’s individual treatment plan and goals have been met. 6. Member’s support system is in agreement with the aftercare treatment plan.

C. Ambulatory Detoxification –See ASAM Level 1 Criteria

D. Day Treatment

The goal of day treatment is to assist children, adolescent with psychiatric disorders plus either an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms to improve functioning so that they can return to educational settings. Adolescents may continue to receive day treatment services over the age of 18, but under the age 22 if admission occurred prior to age of 18. Youngsters that benefit from behavioral health services that have significant challenges in educational settings would benefit from day treatment. Day treatment is focused on treatment services designed to stabilize the youth's adjustment to educational settings, to prepare children for return to education settings and assist with the transition. Services include health referral, medication therapy, verbal therapy, crisis intervention, case management, social, task and skill training and socialization.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1-7 must be met: 1. Member has an active DSM or corresponding ICD diagnosis (excluding mental retardation or other developmental disorders). 2. Member has an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms. 3. Member has the capacity to participate and benefit from day treatment. 4. Treatment at a less intensive level of care (LOC) would contribute to an exacerbation of symptoms. 5. The severity of presenting symptoms is such that member is unable to be adequately treated in a less intensive LOC. 6. Member requires individual intervention and/or part-time center based supervision for safety or to safely facilitate transition to a less intensive LOC. 7. Member's guardian is willing to participate in treatment, as appropriate.	**All of the following criteria must be met**: 1. Member continues to meet admission criteria; 2. Another less intensive LOC would not be adequate to administer care. 3. Treatment is still necessary to reduce symptoms and increase functioning for member to be treated at a less intensive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 6. Coordination of care and active discharge planning are ongoing, with goal of transitioning the member to a less intensive LOC.	**Criteria # 1, 2, 3, or 4 are suitable; criteria #5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is their expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's guardian in agreement with the aftercare treatment plan.

E. Continuing Day Treatment

Continuing Day Treatment shall provide more intensive and rehabilitative treatment and services, which are designed to preserve or enhance an individual's recovery process for living, learning, working and socializing in his or her community of choice, and to develop self-awareness and self-esteem through the exploration and development of personal strengths and interests. A CDT program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity and verbal therapy, and crisis intervention and clinical support services. Participants often attend several days per week with visits lasting more than an hour.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. The member has a DSM or ICD psychiatric diagnosis. 2. The member experiences significant impairment in his or her ability to live, learn, work or socialize in the community due to psychiatric illness. 3. The member exhibits adequate control over his or her behavior. The individual is assessed not to be an immediate danger to self or others and does not require 24-hour medical supervision. 4. The member requires daily structure in order to foster retention and restoration of community living, socialization and adaptive skills. 5. The member has a community-based network of support that can assist them with living in the least restrictive environment. 6. The member has the capacity for reliable attendance, active participation and engagement in all phases of the program. 7. The severity of the presenting symptoms is such that the member is unable to be treated safely or adequately in a less intense outpatient setting. 8. The member demonstrates cognitive functioning and the potential for recovery-oriented goals.	**All of the following criteria must be met:** 1. The individual continues to meet admission criteria, and less intensive care is not appropriate. 2. Treatment is still necessary in order to reduce the individual's symptoms and increase his or her ability to live, learn, work or socialize in the community at a less restrictive level of care. 3. Medication trials have been attempted or ruled out, if appropriate. 4. The individual, family/guardian(s)/caregiver(s) are participating in treatment as clinically indicated and where appropriate, or engagement efforts are underway. 5. Coordination of care and active discharge planning has been initiated with a goal of transitioning the individual to a less intense level of care.	**Criteria 1, 2, or 3 are present; Criteria 4 and 5 are recommended, but optional:** 1. The member no longer meets admission criteria and/or meets criteria for a different level of care, either more or less intensive. 2. The member withdraws consent for treatment and does not meet criteria for involuntary/mandated treatment. 3. The member does not appear to be participating in treatment plan, is not making progress toward goals, nor is there expectation of making progress towards goals. 4. The member's recovery plan and goals have been met. 5. The member's support systems is aware and in agreement with the aftercare treatment plan.

F. Personalized Recovery Orientated Services (PROS)

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing. There are four service components, including Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and clinical treatment.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. The member has a DSM or ICD psychiatric diagnosis. 2. The member exhibits functional deficits related to the severity and duration of a psychiatric illness in any of the following areas: Self-care, Activities of daily living, Interpersonal relations, and/or Adaptation to change or task performance in work or work-like settings 3. The individual has developed or is interested in developing a recovery goal. 4. There is not a lower level of care which is more appropriate.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active recovery goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a PROS level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without PROS services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PROS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional PROS services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

G. Psychosocial Rehab (PSR)

Psychosocial Rehab services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in PSR treatment. 5. An individual must have the desire and willingness to receive rehabilitation and recovery services as part of their individual recovery plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a PRS level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without PRS services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional PSR services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

H. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

An Intensive Psychiatric Rehabilitation Treatment program is time-limited with active psychiatric rehabilitation designed to assist an individual in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities from mental illness and to improve environmental supports. IPRT programs shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development, and discharge planning.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a IPRT level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional IPRT services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

I. Community Psychiatric Support & Treatment (CPST)

Community Psychiatric Support & Treatment (CPST) includes time-limited goal directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in CPST treatment.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a CPST level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without CPST services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional CPST services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

SECTION III: EMERGENCY SERVICES

Overview

This section outlines services provided to members who are experiencing a behavioral health crisis and require an emergency evaluation.

A. Emergency Screening/Crisis Evaluations

Beacon promotes access to Emergency care without requiring prior authorization or notification from the member. Beacon, however, does require a face-to-face evaluation by a licensed clinician for all members requiring acute services. There is no level of care criteria for ESP services.

B. Comprehensive Psychiatric Emergency Program (CPEP)

Comprehensive Psychiatric Emergency Program (CPEP) is a licensed, hospital based psychiatric emergency program that establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Extended Observation Beds operated by the CPEP Program are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. There is no level of care criteria for CPEP services.

C. Mobile Crisis Intervention

Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared

towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

D. Short Term Crisis Respite

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

E. Intensive Crisis Respite

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

SECTION IV: OUTPATIENT BEHAVIORAL HEALTH SERVICES

Overview

This chapter contains service descriptions and level of care (LOC) criteria for the following outpatient behavioral health services:

A. **Outpatient Behavioral Health**
B. **Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)**
C. **Psychological & Neuropsychological Testing**
D. **Applied Behavioral Analysis [ABA]**
E. **Developmental Screening**
F. **Psychiatric Home Care**
G. **Assertive Community Treatment (ACT)**

Beacon's utilization management of outpatient behavioral health services is based on the following principles:

- Outpatient treatment should result in positive outcomes within a reasonable time frame for specific disorders, symptoms and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning;
- Treatment should be targeted to specific goals that have been mutually negotiated between provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction;
- Treatment modality, frequency and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact, as needed;
- Individuals with chronic or recurring behavioral health disorders may require a longer term approach with intermittent visits over extended periods, or sustained contacts with increased intensity of services around periods of relapse or decompensation; and
- Members must have flexibility in accessing outpatient treatment, including transferring.

Please note that visits for psychopharmacology evaluation and management (E/M) and group therapy visits are not subject to this preauthorization process.

A. Outpatient Behavioral Health

Outpatient Behavioral Health (BH) treatment is an essential component of a comprehensive health care delivery system. Individuals with major mental illnesses, chronic and acute medical illnesses, substance use disorders, family problems, and a vast array of personal and interpersonal challenges can be assisted in coping with difficulties through comprehensive outpatient treatment. The goal of BH treatment is to assist members in their achievement of a greater sense of well-being and return to their baseline, or higher level of functioning. Efficiently designed BH interventions help individuals and families effectively cope with stressful life situations and challenges. (See continuation of level of care, next page)

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1 or criteria # 2 – 5 must be met; for Telehealth # 6 and 7 must also be met; and none of #8 - 12 are met: 1. Member has a DSM or corresponding ICD psychiatric or substance use disorder. 2. Member has psychiatric symptoms, behavioral or cognitive impairment consistent with DSM or corresponding ICD diagnoses. 3. Member is experiencing at least moderate symptomatic distress or functional impairment due to psychiatric symptoms in at least one area of functioning (e.g. self-care, occupational, school, or social function) 4. Without treatment, member would be at risk to require a more intensive level of care (LOC). 5. Treatment expectations must include: a. Goal of therapy is to return member to an adequate level of functioning and to help member develop skills to deal effectively with the specific issues of concern. b. Psychopharmacology assessment should be considered on initial evaluation and throughout the treatment process if progress is minimal. c. Frequency of treatment contact matches the intensity/severity of the clinical situation. d. Treatment planning encourages member autonomy and independent functioning (seeing the member on an intermittent basis serves this function). e. From the outset of treatment, clear criteria or goals are developed (with the member) that define progress and indicate when the member will no longer require treatment. f. Treatment is goal-oriented and time-limited with specific focus on the behavioral health issues that require intervention (and that would pose a further risk of impairment if not addressed). g. Therapy with children/adolescents includes family involvement unless contraindicated and documented; individual visits with a child or young adolescent in a school, clinic or home context, where parent/guardian	**All of the following criteria must be met:** 1. Evidence suggests that the defined problems are likely to respond to current treatment plan. 2. Member progress is monitored regularly and the treatment plan modified if member is not making substantial progress toward a set of clearly defined goals. 3. Goals for treatment are specific and targeted to member's clinical issues (A specific treatment plan is in place in the member's chart). 4. Treatment planning is individualized and appropriate to member's changing condition with realistic goals stated. 5. Frequency (intensity) of treatment contact matches the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal). 6. Evidence exists that member is at current risk for higher levels of care if treatment is discontinued. 7. Treatment planning for children and adolescents or adults includes family or other support systems, as appropriate.	**Criteria #1 and any one of # 2 - 8 must be met:** 1. Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others. 2. The member is able to function adequately without significant impairment in psychosocial functioning, indicating that continued outpatient therapy is not required. 3. Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment). 4. Member has attained a level of functioning that can be supported by self-help or other community supports. 5. Evidence does not suggest that the defined problems are likely to respond to continued outpatient treatment. 6. Member is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment approach. 7. Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives. 8. The member no longer meets admission or continued treatment criteria.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
involvement is not indicated, does not meet LOC criteria for effective therapy. h. There is an expectation that member has the capacity to make significant progress toward treatment goals or that treatment will be effective in preventing the member's condition from worsening 6. Treatment is for psychopharmacological evaluation and management as well as psychotherapy. 7. Geography, specialty or linguistic capacity dictates that in-office visits are not within a reasonable distance. **Any of the following criteria is sufficient for exclusion from this LOC:** 8. Treatment focus other than active symptoms of DSM or corresponding ICD diagnoses (e.g., marital communication.) 9. Therapy for personal growth or longer-term character change. 10. Economic or educational issues (e. g., need for housing or a special school program.) 11. Concerns related to physical health without a concomitant behavioral health diagnosis. 12. Treatment as an alternative to incarceration.		

B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)

Home-Based Therapy (HBT) is a short term service for members who require additional support to:

- successfully transition from an acute hospital setting to their home and community, or
- Safely remain in their home or community when they experience a temporary worsening, or new behavioral health need, that may not be emergent, but without timely intervention could result in the need for a more intensive level of care than traditional outpatient treatment.

HBT brings the clinician to the member when there are delays or barriers to the member's timely access to a therapist. The HBT appointment is scheduled to occur within 48 hours of discharge from an acute mental health inpatient setting. The Beacon UR clinician may request that the HBT nurse/therapist visit the member in the hospital prior to discharge to explain HBT and ensure the member's willing participation in the service. This level of care (LOC) requires a safe home environment that poses no safety risk to the HBT clinician. The HBT clinician does not replace the outpatient therapist, but reinforces the aftercare plan, assists to overcome any potential or identified barriers to care, helps identify resources for necessary community-based services, and bridges any delays or gaps in service. The HBT clinician may also work with the member's family to increase understanding of the member's condition and the importance of adherence. HBT may also be deployed to help a member avert acute hospitalization during a brief period of destabilization.

Home Based Therapy-Plus (HBTP)

HBTP is appropriate for members who meet the following criteria:

History of treatment non- which has resulted in poor functionality in the community

1. HBPT is available for members who History of 2 or more admissions in less then 12 months
2. Presence of co-occurring medical and BH disorders
3. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria # 1 - 5 must ALL be met; and at least one of criteria # 6 – 7 must also be met: 1. Member must have a DSM or corresponding ICD diagnosis of a psychiatric disorder. 2. Member can be maintained adequately and safely in their home environment. 3. Member has the capacity to engage and benefit in treatment. 4. Member agrees to participate in psychiatric home based treatment. 5. Member's level of functioning in areas such as self-care, work, family living, and social relations is impaired. 6. Member has social/emotional barriers that cannot be	**Criteria # 1 - 6 must ALL be met:** 1. Member continues to meet admission criteria and another less intensive LOC is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3. Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 4. Member appears to be benefiting from	**Criteria # 1, 2, 3 or 4 are suitable; Criteria # 5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member and/or parent/caregiver do not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and

adequately managed in an office based program setting. 7. Member has history of non-compliance in terms of routine office based services which has recently resulted in placement in a more intensive LOC. **For HBTP, at least one from Criteria 8 through 11 must also be met:** 8. History of 2 or more admissions in less than 12 months 9. Presence of co-occurring medical and BH disorders. 10. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression 11. History of treatment non- which has resulted in poor functionality in the community	the service. 5. Member is compliant with treatment plan and continues to be motivated for services. 6. Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC.	goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan.

C. Psychological and Neuropsychological Testing
Psychological Testing uses standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological Testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance abuse status. Test results may have important implications for treatment planning.

A licensed psychologist performs Psychological Testing, either in independent practice as a health services Provider or in a clinical setting.

Psychological Testing: Beacon reimburses for the following procedure codes for psychological testing:

96101, 96102, 96103 Psychological Testing:

- Includes psycho-diagnostic assessment of personality and intellectual abilities, (e.g., WAIS-R, Rorschach, TAT, MMPI) with interpretation and report, per hour

96118, 96119, 96120 Neuropsychological Testing:

- Includes assessment of neuropsychological functioning that is tailored to the clinical needs of clients; utilizes a variety of assessment devices, which focus on cognitive ability, attention, concentration, language functions, visual perceptual and visual motor functions, executive functions, memory, and motor skills.
- Requires specialized neuropsychological training collected and verified at point of contracting via credentialing

***Beacon Network Inpatient and Acute Residential Treatment Facilities have an all-inclusive per diem rate which covers any needed psychological testing. Beacon does not reimburse individual Providers for psychological testing when it is conducted during the course of an inpatient or an acute residential treatment program stay.**

1. Services to be reviewed by Beacon Health Strategies:

a. **Reasons for referral for psychological testing:**

- Member currently in Behavioral Health (BH) treatment, who has had a complete psychosocial evaluation with a BH provider (including family involvement when the member is a minor) but may require psychological testing to further assess a member's psychological functioning (reality testing, suicidal ideation, anxiety, cognitive functioning) in order to modify or revise an ongoing treatment plan.
  - Testing is not authorized as part of an initial evaluation and a period of psychotherapy and/or a consultation with a psychiatrist is generally recommended prior to a psychological testing referral.
- Evaluations for Attention Deficit Hyperactivity Disorder (ADHD) do not fall in the realm of formal psychological testing. Evaluations for ADHD consist of the completion of rating scales that are reviewed with the member (and his/her family) and a consult with a psychiatrist.

b. **Reasons for referral for neuropsychological testing:**

- Member is experiencing cognitive impairments that impede his/her ability to function on a day-to-day basis.

As examples:

- A member experiencing hallucinations may need a neuropsychological evaluation to rule out organic causes.
- A member with a depressive disorder who is experiencing memory problems, may benefit from an assessment to better understand the type and severity of the memory problems and to assist in treatment planning; or

- A child may benefit from neuropsychological testing to assess the presence of a pervasive developmental disorder or autism.
- Areas of impairment may include: memory, attention, concentration; executive functioning (planning and organization); judgment, receptive and expressive language.

2. Services to be reviewed by Medical side of the Health Plan:

a. **Reasons for referral for neuropsychological evaluation:**

- Member has suffered trauma to the head (e.g., in auto accident) or has suffered from a cerebral insult due to stroke, aneurysm, or other medical condition or biological insult (e.g., degenerative disease, lead poisoning, dementia), resulting in problems with thinking, memory, attention, and/orexecutive functioning.
- The goal of neuropsychological testing, in these situations, is to assess the member's impairment in functioning due to the medical condition or biological insult. This information can then be used to inform medical management.

Note: The member is usually not receiving mental health services.

b. **Reasons for referral for developmental evaluation:**

Pediatrician requests developmental evaluation for young child under the age of four with no behavioral health history, diagnosis, or symptoms.

3. Services that are not covered [Exclusions]:

- Testing for academic, educational or learning problems including: Nonverbal learning disabilities, dyslexia, sensory integration, central auditory processing, speech/language problems and OT or PT issues;
- Psychological evaluations to determine parental competency;
- Testing when the member has used illicit substances in the past 60 days;
- Testing for vocational guidance;
- Testing for legal or administrative purposes;
- A request for re-testing when the member was tested in the past 12 months; and
- Testing at a provider site that is not in the Beacon network.

  *Assessment of possible learning disabilities is provided by the school system in accordance with state and federal mandates.

Please Note: All requests should be in writing on the Beacon psychological testing form and must be performed on an outpatient basis by an in-network licensed psychologist.

C. Psychological and Neuropsychological Testing

Admission Criteria	Criteria for Tests	Non-Reimbursable Tests
The following criteria must apply: **A. Psychological testing: #1 - 3 must be met:** 1. The member has not been tested in the last 12 months or recently enough to make proposed tests duplicative or invalid. 2. The member is presently in active treatment, has had a comprehensive diagnostic evaluation, including an assessment of psychosocial functioning, and has been evaluated by a psychiatrist prior to testing. 3. The member has not been actively using illicit substances for a 2 month period prior to the initiation of testing. **B. Neuropsychological testing: #4 - 5 must be met:** 4. The member is experiencing cognitive impairments; 5. The member has had a comprehensive evaluation by a psychiatrist, psychologist, or developmental/ behavioral pediatrician; **C. In addition, any one of #6 - 10 must be met:** 6. The proposed test are empirically related to the specific question(s) to be answered by the evaluation and cannot be answered using other means of evaluation; 7. Member's symptoms indicate a new or different diagnosis may be operative; 8. Member's functional status has markedly changed and testing is required to assist in establishing appropriate levels of care and treatment planning; 9. The focus or method of a prior evaluation is inappropriate for the member's current needs and the requested evaluation is necessary for appropriate assessment; **OR** 10. It is established that the evaluation is directly relevant to the member's mental health status and current treatment needs.	1. Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the *Mental Measurement Yearbook*, or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association. 2. Tests are administered individually and are tailored to the specific diagnostic questions of concern.	1. Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., *MMPI* or *PIC)* as a general rule. 2. Group forms of intelligence tests. 3. Short form, abbreviated, or "quick" intelligence tests administered at the same time as the *Wechsler* or *Stanford-Binet* tests. 4. A repetition of any psychological tests or tests provided to the same member within the preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes: a. Following such special forms of treatment or intervention such as ECT; b. Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. 5. Tests for adults that fall in the educational arena or in the domain of learning disabilities. 6. Testing that is mandated by the courts, DCYF or other social/legal agency in the absence of a clear clinical rationale. **Please Note:** Beacon will *not* authorize periodic testing to measure the member's response to psychotherapy.

D. Intensive Behavioral Intervention (IBI) (or Applied Behavioral Analysis [ABA]) for individuals diagnosed with Pervasive Developmental Disorder, Not Otherwise Specified (PDD, NOS), Autistic Disorder, or Asperger's Disorder, delivered in the home, or community office setting.
ABA is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. Member has a *DSM-V* diagnosis of PDD, NOS, Autistic Disorder or Asperger's Disorder (collectively referred to as Autism Spectrum Disorder [ASD]) or corresponding ICD codes. 2. Member has been evaluated and diagnosed by a child psychiatrist, developmental pediatrician, pediatric neurologist or psychologist with developmental or child /adolescent expertise, and has a. received a comprehensive medical evaluation to exclude any underlying medical etiologies; b. received formal diagnostic and/or functional assessment (e.g. ABLLS-R, Vineland-II , M-CHAT-R, ADI-R, ADOS-G, CARS2, VB-MAPP or Autism Behavior Checklist) 3. Provider and/or supervisor of the IBI/ABA and treatment plan development is a certified behavioral analyst as evidenced by certification by the Behavior Analyst Certification Board (BCBA). 4. Member has specific, challenging behavior(s) attributable to the ASD (e.g. self injurious, stereotypic/repetitive behaviors, aggression toward others, elopement, severely disruptive behaviors) which result(s) in significant impairment in one or more of the following: a. personal care b. psychological function c. adaptive function d. social function 5. Member can be maintained adequately and safely in their home environment. Member does not require a more intensive level of care due to imminent risk to harm self or others or based on severe maladaptive behaviors.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and does not meet criteria for another level of care (LOC), either more or less intensive. 2. Treatment is still necessary to reduce symptoms and improve function so the member may be treated at a less restrictive LOC. 3. Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives. 4. Supervision of paraprofessionals working on member's case required by a BCBA overseeing treatment. 5. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6. Parent / guardian / caregiver are involved in training in behavioral interventions and continue to participate in and be present for at least 50% of treatment sessions. Progress of parent skill development in behavior	**Criteria # 1, 2, 3, 4, 5, or 6 are suitable; Criterion # 7 is recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC. 2. Member's individual treatment plan and goals have been met. 3. Parent / guardian / caregiver is capable of continuing the behavioral interventions. 4. Parent / guardian withdraws consent for treatment. 5. Member or parent / guardian / caregiver does not appear to be participating in treatment plan and/or be involved in behavior management training. 6. Member is not making progress toward goals, nor is there any expectation of progress. 7. Member's support system is in agreement with the transition/discharge treatment plan.

6. Member's treatment/intervention plan includes clearly defined behavioral interventions with measurable behavioral goals that address the identified challenging behavior(s). Intervention(s) are appropriate for member's age and impairments. 7. Member's challenging behavior(s) and/or level of function can be expected to improve with IBI/ABA. 8. Parent / guardian / caregiver agrees to participate in and be present during at least 50% of treatment sessions (including face to face parent training on behavior management interventions) unless clinically indicated otherwise. 9. Member currently receives no other in home or office based IBI/ABA services.	management interventions is being monitored. 7. As member makes progress evidenced by reduction in rates, intensity and duration of maladaptive behaviors and increase in skill acquisition, service authorization will reflect new presentation. 8. Coordination of care and discharge planning are ongoing with the goal of transitioning member to less intensive behavioral intervention and a less intensive LOC.	

E. Developmental Screening (article 28 and 31 clinics only)

Developmental screening

Developmental screening provides parents and professionals with information on whether a child's development is similar to other children of the same age. Screening always involves the use of a standardized tool. Screening tool questions are based on developmental milestones and designed to answer the question, "Is this child's development like other children of the same age?" Ideally, screening is an ongoing process involving repeat administration of a tool, along with continuous, quality observations made by adults familiar with the child.

Screening does not give a diagnosis, but identifies areas in which a child's development differs from same-age norms. Concerning screening results indicate the need for further assessment to determine a child's strengths and needs.

To read The American Academy of Pediatrics definition of developmental screening, click here (http://www.aap.org/healthtopics/early.cfm). The AAP now recommends developmental screening of all children at ages 9-, 18-, and 30-months. Targeted screening happens when screening is conducted because of concerns about a child.

Article 28 and 31 clinics will be reimbursed for up to 4 units (hours) of developmental screening without prior authorization. For additional units, providers may request the Developmental Screening Supplemental Form.

F. Psychiatric Home Care

Psychiatric Home Care is treatment that is delivered in a member's home or in their living environment in order to treat a DSM or corresponding ICD diagnosis. This service must be provided by an accredited home care agency and the clinical service must be provided by a licensed mental health professional. Psychiatric Home Care may be authorized for a variety of circumstances (e. g., member is homebound or has difficulty ambulating or is unlikely to get to the community mental health provider). For all home care agencies, a written physician order for Psychiatric Home Care services must be in place at the time the service is requested and a physician must be available for consultation and is integrated into treatment plan. The frequency of visits varies depending on level of acuity.

- **Authorization Procedures -** Beacon requires a call from the provider to pre-certify a psychiatric home care evaluation. After the evaluation is completed, the provider will call with clinical information including the member's diagnosis, treatment plan and discharge plan.
- **Written Notification -** Beacon sends an authorization letter to the Provider, including the Prior Authorization Number within 1 business day after the review is completed.
- **Extension requests -** Prior to the end date of the existing authorization, the Provider may request an extension of services.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria # 1 -6 must ALL be met: 1. Member must have a DSM or corresponding ICD diagnosis. 2. Member can be adequately and safely maintained in the home environment. 3. Member is motivated to receive this service and is willing to participate and comply with the developed treatment plan. 4. Member requires coordination of services with other providers and other support services. 5. Member requires assistance to adhere to safe administration of medication regimen. 6. Psychiatric home care is believed to be necessary to prevent placement in a higher level of care.	**Criteria # 1 - 7 must ALL be met and at least one from criteria # 8- 9 must be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Treatment is still necessary to reduce symptoms and improve functioning. 3. Member progress is monitored regularly, and the treatment plan modified, toward a set of clearly defined and measurable goals. 4. Member appears to be benefiting from the service. 5. Member is compliant with treatment plan and continues to be motivated for services. 6. Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC. 7. Continuation of psychiatric home care is believed to be necessary in order to prevent placement in a higher LOC. 8. Member has complex co-morbid issues that require skilled nursing and behavioral health supervision. 9. Member is still not able to follow medication regimen without this level of support (and there is a lack of social support at home.)	**Criteria # 1, 2, or 3, are suitable; criteria # 4 and 5 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or guardian withdraws consent for treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member's individual treatment plan and goals have been met. 5. Member's support system is in agreement with the aftercare treatment plan.

OPIOID REPLACEMENT THERAPY

Opioid replacement therapy is the medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA) approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short term (detoxification) and long term (maintenance) basis.

G. Buprenorphine Maintenance Treatment (BMT)- See ASAM Level 1 Criteria

H. Assertive Community Treatment (ACT)

The purpose of Assertive Community Treatment (ACT) is to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional service delivery approaches. ACT provides an integrated set of other evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of team meetings.

Initial Authorization Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 - 5 must be met; **Criteria 6 & 7 may also be met:** 1. DSM psychiatric and/or substance use disorder diagnosis. 2. Member has severe emotional disturbance causing significant impairment with all levels of functioning or is experiencing an acute life crisis that has disrupted their baseline of functioning, 3. Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision. 4. Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions. 5. Professional or social supports are available to the member outside of program hours and member or their parent/guardian must be capable of seeking them when outside of program hours. 6. Member: a. is stepping down from a higher level of care (LOC) and requires more intensive services than routine outpatient behavioral health treatment or other community based supports; and/or b. has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher LOC. 7. For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria; 2. Another less intensive LOC would not be adequate to administer care. 3. Member continues to require services provided by a multidisciplinary team. 4. ACT is still necessary to reduce symptoms and improve functioning so the member may be treated in a less intensive LOC. 5. Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 6. Family/guardian/caregiver is participating in treatment where appropriate. 7. There is care coordination with behavioral health providers, state or other community agencies. 8. Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC.	**Criteria 1, 2, 3, or 4 are suitable;** **Criteria 5 & 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is there any expectation of progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan.

SECTION V: OTHER SPECIAL BEHAVIORAL HEALTH SERVICES

Overview

This chapter contains other special Behavioral Health service descriptions and level of care criteria for the following:

A. Electro-Convulsive Therapy (ECT)
B. Pre-vocational Services
C. Transitional Employment
D. Intensive Supported Employment (ISE)
E. Ongoing Supported Employment
F. Education Support Services
G. Empowerment Services - Peer Supports
H. Habilitation/Residential Support Services
I. Family Support and Training

Please note: Use of this level of care is specific to a Health Plans authorization requirements.

A. Electro-Convulsive Therapy (ECT)

Electro-Convulsive (ECT) Therapy is the initiation of seizure activity with an electric impulse while the member is under anesthesia. This procedure is administered in a hospital facility licensed to do so by the Department of Health and Mental Hygiene (DHMH). ECT may be administered on either an inpatient or outpatient basis, depending on the member's mental and medical status. Regulations governing administration of this procedure are contained in DHMH regulations

The principal indication for ECT is major depression with melancholia. The symptoms that predict a good response to ECT are early morning awakening, impaired concentration, pessimistic mood, motor restlessness, speech latency, constipation, anorexia, weight loss, and somatic or self-deprecatory delusions, all occurring as part of an acute illness.

Providers must complete a work-up including medical history, physical examination, and any indicated pre-anesthetic lab work to determine that there are not contra-indications to ECT and that there are no less intrusive alternatives to ECT before scheduling administration of ECT. The member must provide separate written informed consent to ECT on forms provided by the DHMD Consent to other forms of psychiatric treatment is not considered to include consent to ECT. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.

Initial Authorization Criteria	Continued Authorization Criteria	Discontinuation Criteria
All criteria must be met: 1. Member must have DSM or corresponding ICD diagnosis of major depression, schizophrenia, or mood disorder with features that include mania and/or psychosis and/or catatonia. 2. ECT is utilized when: a. Member has been medically cleared and there are no intracranial or cardiovascular contraindications; b. There is a need for a rapid definitive response on a psychiatric basis; c. The benefits of ECT outweigh the risks of other treatments. 3. Must meet all of the above and either one below: a. Member has not responded to medication trials; *or* b. Member has a history of positive response to ECT. c. Member requests ECT as a treatment option accompanied by criteria # 2 (a) and (c) above.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and another level of care (LOC) is not appropriate. 2. Member has responded to treatment or there is an expectation that member will respond with further treatment. 3. Member agrees to continue with treatment. 4. Treatment is still necessary to reduce symptoms and improve functioning.	**Any one or more of the following are suitable**: 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member withdraws consent for treatment and does not meet criteria for involuntary mandated treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's natural support (or other support) systems are in agreement with following through with patient care, and the member is able to be in a less restrictive environment.

B. Pre-vocational Services

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

C. Transitional Employment

Transitional Employment services are designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

D. Intensive Supported Employment (ISE)

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

E. Ongoing Supported Employment

Ongoing supported Employment is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for

the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

F. Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

G. Empowerment Services - Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

H. Habilitation/Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community based settings.

These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

I. Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

Please note: Use of this level of care is specific to a Health Plans authorization requirements.

J. Transcranial Magnetic Stimulation

Repetitive transcranial magnetic stimulation (rTMS) is an office-based, noninvasive, nonconvulsive therapy, FDA-approved for patients with unipolar major depression nonresponsive to at least one adequate antidepressant medication trial in the current episode, and not currently on any antidepressant therapy.[1] An electronic coil emits short pulses of magnetic energy over the scalp, which in turn generates a mild electrical current in the superficial, underlying brain tissue. Targeting mood regulating areas of the brain (generally the left prefrontal cortex), the purpose of rTMS is to decrease severity and duration of depressive symptoms. An extremely intensive treatment, rTMS is generally applied five days/week for six weeks, followed by a taper of six treatments over three weeks.[2,3] Response rates (response defined as 50% improvement in objectively measured depressive severity) to this intensity are modest, at 24%, and remission rates even less at 18%.[2] Age over 65[4] and treatment resistance[2,4,5] (defined as nonresponse to at least two full antidepressant medication trials[6]) are each predictive of even less robust response and remission rates with rTMS. Relatively safe, it does have occasional side effects of pain/headache, and there are rare case reports of seizure induction.[7,8] There is no current information on the sustained effect of rTMS and no evidence to support maintenance rTMS. There are no studies, and few case reports on the use of rTMS in pregnancy. (There is evidence to support the relative safety of certain antidepressants and the use of ECT in pregnancy.) There are some contraindications to rTMS, primarily related to possible adverse effects of the electromagnetic fields on devices, implants or magnetic substances. There are also relative diagnostic or medical contraindications, such as dementia, degenerative neurologic conditions, medically unstable conditions, history of stroke or severe head injury.[7,8] The limited potential benefit of rTMS must be weighed against these risks. When the following criteria are met, prior authorization is granted for a six (6) week course of rTMS, up to 30 visits, and six (6) taper treatments over three (3) weeks.

Depression nonresponsive to one antidepressant trial has a better remission rate from a second antidepressant trial (30.6%)[9] than from rTMS (18%),[2] making a second medication trial more efficacious and cost-effective in this group. The remission rates for medication trials after nonresponse to at least two antidepressant trials are significantly less (~13%),[6,9] and even lower for rTMS, making failure of two antidepressant trials the generally accepted definition of treatment resistant depression (TRD). In this difficult to treat population, the relative risks, benefits, time course, treatment history, efficacy, intensity, cost and response maintenance all need to be considered. Depressed elderly, medically complicated individuals with TRD (i.e. those for whom rTMS is a slow, high intensity, low benefit, low efficacy, low risk, high cost treatment) have a better remission rate with ECT (electroconvulsive therapy) (50-60%)[10,11,12] in a shorter period of time (2-4 weeks). ECT, generally provided in a medically monitored setting (e.g., a surgical recovery room) is associated with memory deficits (less and often transient with unipolar treatment[12]), and the risks associated with anesthesia. Thus, ECT is a relatively quick, high intensity, high benefit, high efficacy, moderate risk, and less costly treatment for this population. Successful ECT has a fairly high relapse rate,[11,13] but there is evidence to support the use of medication[13] and/or maintenance ECT to maintain response.[14]

While there is no evidence base to support the use of rTMS as a first-line, cost-efficient treatment for depression or TRD, on a case-by-case basis there may be compelling individual factors that support a trial of this high intensity, low efficacy somatic therapy. The following criteria serve as a guide to ensure appropriate member selection, risk and safety standards, provider qualifications, acute treatment (i.e. not maintenance), and standardized monitoring and documentation of response. The criteria weigh the relative risks and benefits and err on the side of safety, because of the limited potential benefit.

Provider Qualifications and Requirements: The provider of rTMS must be a board certified, appropriately licensed psychiatrist, also certified by the rTMS device manufacturer to provide rTMS. The provider must use an evidence-based, validated depression monitoring tool (e.g. BDI,[15] PHQ-9,[16] or QIDS-SR 16[17]) to identify and document depression severity, response to treatment, and maintenance of response. The provider must submit a current, up dated copy of the self-administered monitoring tool with the initial request for rTMS prior authorization, and after 4 and 6 weeks of rTMS treatment, and when possible, at 6 months after the completion of the course of treatment (i.e. if the member is still in treatment with the psychiatrist).
(See continuation of review criteria, next two pages.)

Initial Authorization Criteria	Continued Authorization Criteria	Discharge Criteria
Criteria # 1 –6 and # 11 and at least one of # 7 – 10 must be met: 1. Confirmed DSM or corresponding ICD diagnosis of Major Depressive Affective Disorder (MDD), severe degree without psychotic features, either single episode or recurrent a. Depression is severe as defined and documented by a validated, self-administered, evidence-based monitoring tool (e.g. QIDS-SR 16, PHQ-9, HAM-D or BDI, etc.). b. Note that active or recent substance misuse must be considered carefully in the differential diagnosis of major depressive disorder. c. Note that diagnosis of MDD cannot be made in context of current or past history of manic, mixed, or hypomanic episode. **AND** 2. Member does not have a DSM or corresponding ICD diagnosis of an acute or chronic psychotic disorder (e.g. schizophrenia or schizoaffective disorder) or current psychotic symptoms. **AND** 3. Member is at least 18 years of age. **AND** 4. The rTMS treatment is delivered by an FDA-approved device in a safe and effective manner following the manufacturer's protocol and parameters with no modifications unless supported by published scientific evidence. 5. The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy, and directly supervises the procedure (on site and immediately available). **AND** 6. During the current episode the Member has had a trial of evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by a validated, self-administered, evidence-based monitoring tool **AND** 7. Member has treatment resistant depression (TRD) as evidenced by lack of clinically significant response (less than 50% improvement in depressive symptoms documented on a validated, evidence-based monitoring tool), with good adherence, to at least four (4) psychopharmacologic trials, in the current episode. a. Trials must be at or above the minimum effective dose and duration b. Trials must be from at least 2 different medication classes c. Trials must include at least two (2) evidence-based augmentation	**All of the following criteria must be met:** 1. Member continues to meet initial authorization criteria and does not require a higher LOC. 2. Member has been adherent and agrees to continue with the treatment plan. 3. Member has not yet completed the full course of treatment (i.e. 5 treatments per week for 6 weeks, followed by 6 taper treatments over 3 weeks) 4. Provider has administered and submitted the required timely updated standardized depression severity tool (as in Prior Authorization Criteria #9)	**Any one or more of the following criteria are suitable:** 1. Member has completed the acute course of 5 treatments per week for 6 weeks, and up to 6 taper treatments over 3 weeks (further treatment is considered to be maintenance, for which there is no evidence) 2. Member withdraws consent for treatment 3. Member no longer meets authorization criteria and/or meets criteria for another LOC, either more or less intensive. 4. Provider has failed to monitor, document and/or report member response to treatment (as in Prior Authorization Criteria #9)

therapies **OR**

8. Inability to tolerate psychopharmacologic agents as evidence by four trials of psychopharmacologic agents with intolerable side effects **OR**
9. Member has a documented history of response (at least 50% improvement in depressive symptoms documented on a validated, evidence-based monitoring tool) to a previous course of rTMS, now has a relapse after remission and meets all other Admission Criteria **OR**
10. History of previous response to electroconvulsive therapy (ECT), or inability to tolerate ECT, and rTMS is considered a less invasive treatment option.
11. Member does ***not*** have any of the following:[7]
    a. History of seizures or seizure disorder (excluding ECT-induced seizures or febrile seizures in infancy requiring no further treatment)
    b. Neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system.
    c. Implanted medical device located <30 cm from the rTMS magnetic coil, including but not limited to implanted automatic defibrillators, pacemakers, or vagus nerve stimulators.
    d. Conductive, ferromagnetic or other magnetic-sensitive metals implanted in the head which are non-removable and within 30 cm of the TMS magnetic coil. Examples include shunts, clips, stents, cochlear/otologic implants, implanted electrodes/stimulators, bullets, pellets, metallic fragments and metallic tattoos.
    e. Vagus nerve stimulation (VNS) leads in the carotid sheath
    f. Magnetically activated (not amalgam) dental implants

[1] FDA definition in letter to Neuronetics, Inc. Re: K061053; NeuroStar® TMS System, Evaluation of Automatic Class III Designation, Regulation Number: www.accessdata.fda.gov/cdrh_docs/pdf6/K061053.pdf, accessed on 4/25/2011.
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