

# Levels of Care Criteria

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# Levels of Care Criteria Contents

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# Section A:

## Determining Medical Necessity



Section A: Determining Medical Necessity

### Levels of Care Criteria

## Determining Medical Necessity:

In order to ensure that medical necessity will be certified under the client's health benefit plan, Clinical Case Manager (CCM) and Peer Advisors (PA) must ascertain that treatment meets all of the criteria for medical necessity as defined below:

- o Medically necessary means a service or supply which the Employee Assistance Network (EAN) has determined:
  - i. Is adequate and essential therapeutic response provided for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific Participant's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent in ICD-9CM); and
  - ii. Is reasonably expected to improve the Participant's illness, condition or level of functioning; and
  - iii. Is safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications; and
  - iv. Is the appropriate and cost-effective level of care that can safely be provided for the specific Participant's diagnosed condition in accordance with the professional and technical standards adopted by EAN.

## Determination of Medical Necessity and the Review Process

The following sections explain the elements of medically necessary services.

### Section A: Determining Medical Necessity

#### A service must be adequate and essential for the evaluation/treatment of a mental disorder

- i. Is an adequate and essential therapeutic response provided for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific Participant's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent in ICD-9CM)

To be considered medically necessary, services which are provided or proposed must be those services (e.g., psychotherapy, psychopharmacology) which the patient clinically requires—no more and no less.

The adequacy of treatment refers to its clinical appropriateness, completeness, and timeliness. Essential treatment means treatment that is neither no more nor less than what is clinically appropriate for the patient at a specific point in time.

Treatment may be adequate but not essential if a more restrictive and costly alternative is used than the patient clinically requires. Treatment may be essential but inadequate, if for example, a patient is hospitalized for a severe mental disorder but is not given appropriate medication in a timely manner.

To be considered medically necessary, treatment must address a mental disorder. Treatment intended solely for self-improvement or for normal life stress reaction is not medically necessary. Treatment must address a recognized DSM-IV diagnosis (qualified by all five axes)—with the exception of certain DSM-IV diagnoses for which medical/psychiatric intervention is generally not appropriate. A provider's rationale for treatment should reflect clinical indications and symptoms which have been appropriately interpreted as a diagnosis consistent with one of the categories to be found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, or ICD-9CM.

The EAN's protocols are not diagnosis-based. EAN's criteria for determining the appropriate level of care for patient placement are based on Severity of Illness (SI)/Intensity of Service (IS).

#### Section A: Determining Medical Necessity

### A service must be expected to improve an individual's condition or level of functioning

- ii. The participant's illness or condition is reasonably expected to improve to a level of functioning
  - o To be considered medically necessary, treatments must be active and have a reasonable clinical expectation that such treatment will improve the patient's condition or level of functioning.
  - o This means a positive response to treatment would be expected based on common clinical experience with individuals with a similar/same clinical presentation. However, with chronic conditions (e.g., schizophrenia), follow-up treatment to maintain stabilization may be reimbursable under the plan.

### A service must meet national standards for mental health professional practice

- iii. Practice is safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health substance abuse care professionals or publications. New treatment modalities currently deemed experimental by the majority of resources of national standards for mental health professional practice will not be considered safe and effective until recognized as best practice by national standards.

EAN clinical review policies and criteria have been developed by drawing upon the resources of national standards for mental health professional practice. Such resources include clinical information from:

- American Psychiatric Association
- American Psychological Association
- American Academy of Child & Adolescent Psychiatry
- American Society of Addiction Medicine
- Civilian Health & Medical Program of the Uniformed Services (CHAMPUS)
- InterQual
- The National Institutes of Mental Health
- The National Institutes of Alcohol Abuse & Alcoholism
- The National Institutes of Drug Abuse
- The DATTA Program of the American Medical Association
- Blue Cross & Blue Shield Association
- Standard psychiatric tests
- Current publications in professional journals & books

#### Section A: Determining Medical Necessity

To be considered medically necessary, treatment must be rendered by appropriately licensed and qualified (e.g., credentials, experience) mental health professionals, i.e.,:

- Psychiatrists
- Clinical psychologists
- Psychiatric clinical nurse specialist(s)
- Psychiatric social workers
- Marriage & Family therapists (where benefit plan allows)
- Licensed Professional Counselor(s) (where benefit plan allows)
- Pastoral Counselors (where benefit plan allows and must be adequately supervised)

In addition, treatment facilities and settings must be appropriately licensed and qualified to provide the appropriate level of care.

***Note: Specific client benefit plans may expand or limit the types of providers.***

A service must be provided at the most cost-effective level of care

- iv. Is the appropriate and most cost-effective level of care that can safely be provided for the specific Participant's diagnosed condition in accordance with the professional and technical standards adopted by EAN.

As outlined in (1) above, treatment must be "adequate and essential."  
Treatment at the most appropriate level of care is care that is provided to meet a specific beneficiary's clinical needs (structure, process, outcome) at the most reasonable cost.

## Severity of Illness (SI)/Intensity of Service (IS) Criteria

Severity of Illness and Intensity of Service (SI/IS) criteria are two parameters used by EAN to determine the appropriate level of care.

Severity of Illness (SI) criteria for a given level of care represent signs, symptoms, and functional impairments of such a nature and severity as to require treatment at a specified level at a given point in time. These criteria address the question:

### Section A: Determining Medical Necessity

- o "What specific dysfunction exists as a result of a present DSM-IV diagnosis?"

Intensity of Service (IS) criteria should match the patient's dysfunction. These criteria represent therapeutic modalities that by virtue of their complexity and/or attendant risks require a specified level of care for their safe, appropriate, and effective application. These criteria address the question:

- o "does the patient's condition (behavior, symptoms, etc.) warrant this level of care (is it medically necessary)?"

Diagnosis does not determine the necessity for treatment at a given level. Different patients with the same diagnosis or one patient over time can exhibit a wide range of severity of signs and symptoms of illness.

Therefore, both the SI and IS criteria must be used as the framework for determining the level of care required by an individual patient. The applicability of the SI/IS criteria to an individual case will depend upon the data obtained by the CCM from the provider or beneficiary.

## Evaluating Medical Necessity for Continued Treatment

Three situations exist:

- A. The original SI/IS criteria, present at the start of care continue to apply, and no other level of treatment would be adequate.

- B. New symptoms have emerged so that additional SI/IS criteria may be cited from among the criteria, and no other level of treatment would be adequate.
- C. Symptom acuity and risk have significantly decreased so that a shift to another level of care appears imminent.

The following criteria should be present for continuation of a treatment plan:

- Progress in relation to specific symptoms or impairment is clearly evident and measurable in describable and observable behavioral terms.
- Active evaluation and realistic treatment are under way with cooperation of the patient and family, and timely relief of symptoms is evident.
- The patient and family are participating, to the extent he/she or they are medically and psychologically capable, with a program that is considered adequate to alleviate the signs and symptoms justifying admission.

#### Section A: Determining Medical Necessity

- Treatment goals are realistic and established within an appropriate time frame for this level of treatment.
- All services and treatments are carefully structured to achieve maximum results in the timeliest way possible.

*If continued stay criteria are no longer met, there are strong indications for discharge. If the patient's condition does not improve or it worsens, consideration must be given to a change in the treatment plan and/or treatment site/level of care.*

#### Who may provide a review

For initial and concurrent reviews of programmatic treatment, information may be provided by any of the following individuals:

- The physician with responsibility for management of the case, including the decision to admit and discharge
- A licensed professional who is a key member of the treatment team
- A substance abuse counselor
- A facility-designated utilization review professional who has access to the treatment team meetings and to the treating physician

#### Protocol for non-certification determinations

When the CCM and Clinical Review Team concludes that the proposed treatment of a beneficiary may not be medically necessary based on criteria for medical necessity:

- The CCM will attempt to review these concerns with the provider the same business day.

- If the treating clinician cannot be reached, a message should be left indicating that the call pertains to a question of medical necessity determination.
- The provider will be directed to the Appeals process by EAN.

## Section A: Determining Medical Necessity

### The provider/beneficiary files a request for appeal

The provider/beneficiary may request an appeal of a non-certification determination. There are three levels of appeal that will be conducted in consecutive order.

#### Level I Appeal

The provider/beneficiary may contact the CCM by telephone who worked on the case review to discuss the determination and recommendations related to the determination. Any clinical information that was not provided in the original Clinical Evaluation Form documentation can be provided to CCM at that time. The CCM will then review the appeal request and any new information with the clinical team for determination, which will happen within one week or five business days of the provider/beneficiary contact.

#### Level II Appeal

The provider/beneficiary may send a written request of appeal to EAN Clinical Supervisor for review, which will include a copy of the medical record and all essential clinical documentation. Since the beneficiary is in a current course of treatment, it is important that the participating provider request a Level II appeal as soon as possible. It is also essential that the participating provider send in the written appeal and the medical record as quickly as possible, preferably by overnight mail. The participating provider is responsible for costs of providing the medical record to EAN for the Level II Appeal. The EAN Clinical Review Team will make a determination no later than one week, or five business days, from the day EAN receives the medical record.

#### Level III Appeal

If agreement is not reached with the provider/beneficiary and the Clinical Review Team on the treatment and certification, a case review from the Medical Director will be requested by EAN. The case review will include a review of the medical record provided by the provider and the EAN case file. The Medical Director will review the case files and essential information and make recommendations on medical necessity and course of treatment. The process for the Level III will take no longer than 30 days.

## Section A: Determining Medical Necessity

### Time limit for Appeals

No appeals will be considered after sixty (60) days from the determination and notification to the provider of the non-certification.

### Hold Harmless Requirement

The participating provider is contractually responsible to hold the beneficiary harmless for any charges incurred until the entire appeals process is completed. If a beneficiary wishes to continue treatment once the appeals process is completed, the participating provider must obtain the beneficiary's written consent to be financially responsible for any care thereafter. The beneficiary's consent must be signed and dated on or after the date that the appeals process is completed. EAN may request a copy of the consent form.

Section B:

Adult Psychiatric Treatment

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## Section B: Adult Psychiatric Treatment

### Adult Psychiatric Treatment

This section details EAN's Adult Psychiatric Treatment criteria for admission and continued stay at the following levels:

- Inpatient
- Partial Hospitalization
- Intensive Outpatient Program

The following information should be consulted in assessing whether all the criteria for the medical necessity of the treatment have been met. The criteria used for adult inpatient treatment are those nationally recognized as the standard for professional mental health practice.

### General Justification for Inpatient Admission

A patient may be considered to require an acute hospital level of care if he/she requires not only 24-hour skilled nursing within the structure of a therapeutic milieu but also an intensity of service necessitating close medical supervision by a physician. The need or a level of medical care requiring 24-hour hospital services must be reflected in the data which documents the physician's rationale for admission.

The following are general examples:

- Existence of signs and/or symptoms and/or the diagnosis of any acute psychiatric condition which is, or potentially is life or organ-threatening and requires medical and nursing care.
- Deterioration of the clinical conditions of a patient with pre-existing illness such that signs and/or symptoms of an illness exist which are, or potentially are life or organ-threatening and require intense medical treatment and nursing care.
- Need for procedure(s) that cannot or should not be carried out on an outpatient, residential or partial hospital basis, due to the patient's condition and/or the nature of the procedure(s) involved.
- Unresponsiveness to outpatient management, with the reasonable belief that intensive therapy to be provided on an inpatient basis will bring more positive therapeutic results.

## Section B: Adult Psychiatric Treatment

In assessing SI/IS criteria for inpatient treatment, the following must be evaluated in a framework which considers the individuality of each patient:

- Patient's pre-morbid functioning and contrast to baseline posed by this episode of illness.
- Degree of danger and threat to life of self-mutilative or other suicidal attempts, destruction to property and danger to others.
- Number and severity of stressors in life to include stressors encountered immediately prior to admission and those which necessitate hospitalization.
- Degree of subjective distress felt by the patient.
- Psychopathology and its adverse impact on functioning in the family and community environments.
- The need for psychiatric treatment and evaluation vs. the need for control with the penal system or assistance within the social services system.
- Court ordered or mandated treatment must meet all tests for medical necessity in order for payment to be made under a health benefit plan.

## Severity of Illness (SI) Criteria for Inpatient Hospitalization

A person will be considered a candidate for acute inpatient psychiatric treatment if the patient presents with at least one of the following:

- 1) A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, impulsivity, or concurrent intoxication.
- 2) The patient expresses current suicidal ideation and is assumed to be in "real and present danger" (e.g., has a plan and means for suicide).
- 3) There is recent history of significant self-mutilation, significant risk-taking, or other self-endangering behavior.
- 4) Threats or acts of physical harm have occurred, and there is a clear risk of escalation or repetition of this behavior in the near future.
- 5) There has been destructive behavior toward property which endangers others, such as setting fires.

### Section B: Adult Psychiatric Treatment

- 6) Disordered/bizarre behavior or psychomotor agitation or retardation interferes with the activities of daily living to such a degree that the patient cannot function at a lower

level of care.

- 7) Disorientation or memory impairment endangers the welfare of the patient or others.
- 8) The patient is unable to maintain adequate nutrition, shelter, or other essentials of daily living due to a psychiatric disorder, and family/community support cannot be relied upon to provide essential care. \* \*
- 9) A severe or life-threatening condition of an atypical or unusual complexity has failed to respond to less intensive levels of care and resulted in substantial dysfunction.
- 10) The patient has a recent history of drug ingestion with a strong suspicion of intentional overdose. Such a patient should no longer require intensive medical monitoring but could require treatment of psychiatric and/or substance abuse disorder.
- 11) The patient has experienced severe or life-threatening side effects of an atypical complexity from using therapeutic psychotropic drugs.

*\*\*This does not result from a primary eating disorder.*

## Intensity of Service (IS) Criteria for Inpatient Hospitalization

If the patient requires at least one of the following services, he/she meets IS criteria for admission to an inpatient psychiatric treatment facility:

- 1) Close and continuous skilled medical observation and supervision to make significant changes in psychotropic medication.
- 2) Indications of intravenous therapy to modify or prevent life-threatening complications resulting from overdose or withdrawal during detoxification where no other adequate treatment site is available.
- 3) Continuous observation and control of behavior (e.g., isolation, restraining and other suicidal/homicidal precautions) to protect property, the patient and others.
- 4) Close and continuous skilled medical observation due to side effects of psychotropic medication.

### Section B: Adult Psychiatric Treatment

- 5) A comprehensive multi-modal therapy plan requiring close medical supervision and coordination due to its complexity and/or the patient's signs and symptoms.

## Treatment Plan for Inpatient Hospitalization

Once it has been determined that the SI/IS criteria has been met for inpatient treatment, the appropriateness of the treatment plan must be evaluated. The treatment plan should include the following:

- A comprehensive assessment of previous treatment for psychiatric illness and substance abuse.
- An evaluation of the outcome of previous treatment (including a description of treatment modalities).
- An assessment of the presenting illness as a new symptom or an exacerbation of a chronic illness.
- A description of the initial plan of treatment for the current hospitalization which specifically addresses the clinical presentation of the patient and is not a repetition of a previously failed plan of treatment.
- The treatment planned must be based on a comprehensive assessment of the patient's clinical condition, the description of which will validate the DSM-IV criteria for the stated working diagnosis.
- The acute psychiatric symptoms (target behaviors) which require stabilization during acute hospitalization must be clearly identified, with the goals and objectives for the treatment stated in measurable terms with a time frame established for the completion of treatment objectives.
- The specific interventions and frequencies for each treating discipline must be focused to assist the patient in meeting treatment goals and objectives resulting in stabilization of acute symptoms, must be clearly described in the medical record documentation, be appropriate to the clinical condition acceptable standards of medical practice and represent a skilled level of professional care.

## Section B: Adult Psychiatric Treatment

### Discharge Plan for Inpatient Hospitalization

A comprehensive discharge plan should include a thorough assessment of:

- The social, familial, occupational support system available to the patient at the time of discharge.
- Identified stressors in the patient's environment and the patient's degree of clinical vulnerability to these stressors following a course of inpatient treatment. (Anticipated

condition on discharge)

- The aftercare resources available to the patient for the rendering of professional services post-discharge within a reasonable location of the patient's residence. There should be identification of specific providers and programs as opposed to general plans such as "outpatient follow-up". The criteria for qualifying for the provision of such services as well as the financial resources required in order to secure their provision will be part of the assessment.
- Factors which may place the patient at risk at the time of discharge:
  - Lack of social, familial, occupational, recreational support system
  - Substantiated chronic family instability with previously failed dispositions to the environment
  - Previous chronic failure to follow through on recommended outpatient therapy
  - History of physical abuse within the family setting on a continuing basis
  - History of chronic self-destructive gestures or threatening gestures to others which will require a level of supervision and support not available in the family setting
  - Presence of medical illness requiring a level of care or skilled supervision not available in the home environment
  - History of active substance abuse and no specific treatment plan to address it

## Psychiatric Partial Hospital Treatment

Partial hospitalization provides stabilization of acute, severe mental illness; therapeutically-supported alternative to inpatient care; threat of chronic illness that is deteriorating, and restoration of patients to a level of functioning that allows them to be safely maintained in the community.

### Section B: Adult Psychiatric Treatment

Partial hospitalization may be appropriate when a patient:

- Has acute-stage symptoms
- Does not meet the criteria for 24-hour inpatient treatment, but could require up to 6-8 hours of care up to six times per week
- Needs the availability of psychiatric services up to six days per week

Partial hospitalization may also provide supportive transitional services to patients who:

- Are no longer acutely ill
- Require minimal supervision to avoid risk
- Are not fully able to re-enter the community or the workforce

## Severity of Illness (SI) Criteria for Partial Hospitalization

A person is considered a candidate for admission to, or continued stay in, a psychiatric partial hospital program if the patient presents with at least one of the following:

- 1) Treatment of a psychiatric disorder and co-morbid substance abuse (when present) requires a structured psychiatric setting which can also appropriately treat the substance abuse disorder.
- 2) Suicidal ideation or non-intentional threats or gestures may be present. (Recent suicide attempts, severe hopelessness, or the presence of a well-defined suicide plan would be a relative contraindication for partial hospital care.
- 3) There is a recent history of self-mutilation, serious risk-taking, or other self-endangering behavior.
- 4) Threats of physical harm exist, but do not clearly require 24-hour protected, controlled or monitored environment.
- 5) There have been destructive fantasies, threats or behavior towards property which may or may not include behavior that threatens others (e.g., fire setting); and there is evidence of patient capacity for reliable attendance at the partial hospital program and compliance with a medication regime; the risk to self, others, or property is not so serious to require 24-hour medical or nursing supervision.
- 6) Disordered or bizarre behavior psychomotor agitation or retardation interferes with activities of daily living to the extent that psychiatric structure and supervision are required for a significant portion of the day.

## Section B: Adult Psychiatric Treatment

- 7) A disorder of mood or thought interferes with the ability to fully resume work, family, or school responsibilities unless psychiatric/social/vocational/rehabilitation services are provided.
- 8) As a result of an active psychiatric disorder, the patient is able to maintain adequate nutrition, shelter, or other essentials of daily living only with structure and supervision for a significant portion of the day and with family/community support when away from the partial hospital program.
- 9) The patient has experienced side effects of atypical complexity resulting from psychotropic drugs.

## Intensity of Service (IS) Criteria for Partial Hospitalization

If at least one of the following conditions is met, the patient satisfies IS criteria for admission or continued stay in a partial hospital program:

- 1) Routine medical observation and supervision are required to effect significant regulation of psychotropic and/or other medication.

- 2) Routine nursing observation and behavioral interventions are needed to maximize patient functioning and minimize risks to self, others, and property.
- 3) Routine medical observation and supervision are necessary to minimize serious side effects (e.g., hypotension, arrhythmia) of medication or to maximize medical management of co-existing medical conditions.
- 4) A comprehensive, multi-modal treatment plan requiring medical supervision and coordination is required because:
  - a treatment plan formulated during inpatient hospitalization has enabled the patient to function without continuous observation and supervision, but not at the outpatient level;or
  - in the absence of partial hospital care, the patient would require admission to full inpatient care, (e.g., acute partial hospital care functions as an alternative).

## Section B: Adult Psychiatric Treatment

### Psychiatric Intensive Outpatient Programs

A psychiatric Intensive Outpatient Program (IOP) for adults is a multi-disciplinary, multi-modal program of structured mental health services. Most programs initially provide, at a minimum, nine hours a week of structured services. Such a program is less restrictive than a partial hospital program but significantly more intense than outpatient psychotherapy and medication management. IOP should be used to intervene in complex or refractory clinical situations which would otherwise result in hospitalization. IOP should not be confused with longer term structured day programs intended to achieve or maintain stability for serious and prolonged mentally ill patients.

Clinical interventions available should include individual, couple and family psychotherapy, group therapies such as life planning skills and special issue or expressive therapies, which would be included in the per diem, may be provided but must not be standardized in content or duration: that is, they must have a specific function within a given patient's treatment plan. Any diagnostic testing billed separately must have the prior approval of the CCM or utilization review clinician.

All treatment plans must be individualized and should focus on stabilization and discharge to community outpatient treatment and support groups as needed. When the patient has been in ongoing treatment with a clinician outside the IOP, that clinician should be involved in patient assessment and kept aware of progress. The treating clinician will generally resume treatment of the patient at the conclusion of the program.

## Severity of Illness (SI) Criteria for Psychiatric Intensive Outpatient Treatment

A person will be a candidate for IOP if at least one of the following criteria is met:

- 1) Despite a crisis or exacerbation of symptoms, the individual can function in the community and can maintain at least some pre-morbid daily activities such as work or school attendance, completion of household or family responsibilities.
- 2) Suicidal ideation or self-injurious behavior may be present intermittently, but patient is considered low risk for significant self-harm at this time, or adequate surveillance can be provided by a significant other.
- 3) Complex family dysfunction interferes with the ability of the identified patient to benefit from traditional outpatient treatment without family involvement.
- 4) Non-compliance make outpatient psychotherapy management impossible without team intervention and structure.

### Section B: Adult Psychiatric Treatment

- 5) Psychosocial stressors have produced a crisis in ongoing treatment which requires multi-disciplinary efforts at stabilization.
- 6) Patient has stabilized during acute hospital care but requires transitional services beyond the scope of outpatient psychotherapy and less than partial hospitalization.

## Intensity of Service (IS) for Psychiatric Intensive Outpatient

IS criteria for IOP requires all of the following services:

- 1) Psychiatric consultation and professional direction are available to provide assessment, treatment review and protection.
- 2) An individualized, multi-modal and multi-disciplinary outpatient treatment plan is provided which targets an acute and complex clinical situation.
- 3) Treatment duration between one and eight weeks.
- 4) Psychosocial factors which may prolong a crisis can be rapidly addressed by appropriate staff.

## Section C:

# Adult/ Adolescent Substance Abuse Treatment

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## Section C: Adult/Adolescent Substance Abuse Treatment

### Adult/Adolescent Substance Abuse Treatment

EAN has developed Severity of Illness (SI) criteria, based on national standards, for the following types and levels of treatment available for substance abuse:

- Acute inpatient detoxification, acute care
- Ambulatory detoxification, partial hospital or outpatient
- Intensive outpatient rehabilitation, hospital based or freestanding
- Inpatient rehabilitation, hospital based or freestanding residential

This section describes the information required and the criteria applied when EAN reviews cases with a primary diagnosis of substance abuse. These criteria apply to adolescents as well as adults.

### Inpatient Detoxification

Inpatient detoxification treatment requires daily medical supervision and can occur in acute inpatient psychiatric or substance abuse units, acute inpatient medical/surgical units, or in properly equipped residential substance abuse programs. Most detoxification is completed in three to five days; however, certain prescriptive medications may require longer detoxification.

Simple intoxication is not justification for acute inpatient detoxification unless there is substantive, objective evidence that the patient's physiologic dysfunction represents an active threat to life or vital bodily function.

### Severity of Illness (SI) Criteria for Acute Inpatient Detoxification

The patient meets SI criteria for acute inpatient detoxification if the patient has a substance abuse disorder as described in the DSM-IV and at least one of the following signs and symptoms:

1. Vital signs indicate hospitalization is necessary to prevent permanent impairment or threat to life (any of the following)

- Systolic or diastolic reading increase or decrease 30mm Hg from the patient's baseline blood pressure.
- Heart rate increases or decreases 30 beats per minute from the patient's normal resting heart rate.

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- Acute disturbances of heart rhythm, such as a heart block or premature beats associated with ventricular fibrillation threaten.
  - Respiratory rate changes 30% against the patient's normal resting respiratory rate.
  - Increased sympathetic nervous system activity, such as papillary dilation, perspiration, or dry mouth.
  - The level of consciousness fluctuates from mild cloudiness to stupor or a state of hyper-alertness.
2. Any of the eleven severity of Illness Criteria for Adult Psychiatric Inpatient Treatment found in Section B, either secondary to withdrawal/toxicity or as a concomitant condition.
  3. Life-threatening medical states exist, such as uncontrolled emesis, acute pancreatitis, hepatorenal syndrome, acute alcohol hepatitis, or Wernicke's encephalopathy. (It is expected that these patients will be admitted to a medical substance abuse unit.)
  4. History of life-threatening withdrawal episodes.
  5. Blood alcohol level is 0.35 or greater.

## Intensity of service (IS) Criteria for Acute Inpatient Detoxification

IS criteria for acute inpatient detoxification requires all of the following services:

1. Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions.
2. 24-hour nursing care with evidence of close and frequent observation and restraint or seclusion if needed to prevent suicide or homicide.
3. Medical therapy, which must be actively supervised by the attending physician and re-evaluated daily, in order to stabilize the patient's physical condition.

## Section C: Adult/Adolescent Substance Abuse Treatment

### Ambulatory Detoxification

Ambulatory detoxification is indicated when the patient experiences physiological dysfunction during withdrawal but life or significant bodily functions are not threatened.

The patient may or may not require medication, and twenty-four hour nursing observation is not required and can be provided in an intensive outpatient program.

### Severity of Illness (SI) Criteria for Ambulatory Detoxification

A patient must have both of the following signs and symptoms to meet the SI criteria for ambulatory detoxification:

1. Vital signs and neurological function may be altered but are not medically considered to represent a threat to life or bodily functions.
2. Symptoms of withdrawal and disordered behavior may interfere with activities of daily living but not to a degree that poses risk to the patient or others.

### Intensity of Service (IS) Criteria for Ambulatory Detoxification

A patient requiring all the services listed below meets IS criteria for ambulatory detoxification:

1. Vital signs monitored by nursing staff at periodic intervals evaluate withdrawal symptoms
2. Availability of physician and licensed nurse for medical monitoring
3. Individualized treatment plans address the patient's specific physical, psychological, and behavioral problems, and the ramifications of the patient's abuse of drugs

### Intensive Outpatient Rehabilitation

Intensive Outpatient (IOP) rehabilitation is indicated for patients who require structured, multi-modal treatment to achieve abstinence and sustain recovery work. This enables patients to maintain residence in the community and continue their work, attend school, and be a part of family life.

## Severity of Illness (SI) Criteria for Intensive Outpatient Rehabilitation

If the patient has a substance abuse disorder as described in the DSM-IV and all of the following signs and symptoms, the patient meets SI criteria for outpatient intensive rehabilitation:

1. The patient does not manifest signs or symptoms of life-threatening withdrawal requiring acute detoxification.
2. The patient is unable to maintain abstinence without a structured environment during a portion of the day which offers professional counseling and other rehabilitation services.
3. The patient is able to function in a community-based environment. There is, however, significant impairment in social, medical, family, or work functioning.
4. The patient's living situation and support system are supportive of his/her recovery efforts.

## Intensity of Service (IS) Criteria for Intensive Outpatient Rehabilitation

A patient who requires all of the following services meets IS criteria for intensive outpatient rehabilitation:

1. Individualized treatment plans address the patient's specific physical, psychological, and behavioral problems, and the ramifications of the patient's abuse of drugs.
2. Multi-modal treatment that includes:
  - a. Didactic presentations
  - b. Individual counseling
  - c. Family therapy
  - d. Physician services
  - e. Regular urine and/or serum drug screening
  - f. Sub-acute detoxification if necessary
  - g. Strategies for relapse prevention to include community and social support systems in treatment
3. A structured program continuum ranging from three times a week, three hours per day to the equivalent of partial hospitalization (up to eight hours, six days per week)

## Inpatient Rehabilitation

Inpatient rehabilitation facilities provide 24-hour treatment with several therapeutic services.

## Severity of Illness (SI) Criteria for Inpatient Rehabilitation

A patient with a substance abuse disorder who satisfies criteria (1) or (2) and (3)-(4) or criterion (5), meets SI criteria for inpatient rehabilitation:

- 1) History of failed structured outpatient rehabilitation with less than one year sobriety/abstinence following completion of the outpatient program.

Or

- 2) History of failed structured outpatient rehabilitation with less than one year sobriety/abstinence following completion of the outpatient program. (Adolescents do not require previous attempts to meet SI criteria.) Treatment failure may also be evidenced by a sustained attempt to use a 12-step program without achieving abstinence.
- 3) Serious impairment in social, family, medical or occupational functioning necessitates skilled observation and care.
- 4) Destructive influences in the home environment jeopardize the patient's ability to remain abstinent.

Or

- 5) Concomitant psychiatric disorders significantly interfere with the ability to participate in less intensive rehabilitation services.

*Note: Criterion (1), or (2) may be waived by the CCM if there is documentation that the patient is experiencing a life crisis which is a critical contributing factor to the social, family and/or occupational impairment discussed in criterion (3).*

*Note: If reviewers cite criterion (5), they must document that the facility can provide psychiatric consultation daily and psychotropic medication as appropriate.*

Section C: Adult/Adolescent Substance Abuse Treatment

## Intensity of Service (IS) Criteria for Inpatient Rehabilitation

A patient who requires at least one of the following services meets IS criteria for inpatient rehabilitation:

- 1) Immediate availability of 24-hour nursing and medical care to monitor late sequelae of a withdrawal syndrome and to ensure the patient's safety

Or

- 2) Immediate availability of 24-hour nursing and medical assessment and observation to monitor severe underlying physical disease or psychiatric disorder
- 3) Isolation from the substance of choice and from destructive home influences

*Note: Since substance abuse is a chronic illness and recovery is a lifelong process, such isolation may have therapeutic value when other efforts have failed. However, repeated use of the approach in the face of treatment failure is not effective. Other levels of care, including halfway house residence/group homes, should be considered.*

## Section D:

# Child/Adolescent Psychiatric Treatment

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Section D: Child/Adolescent Psychiatric Treatment

## Child/Adolescent Psychiatric Treatment

### Levels of Treatment

EAN's Severity of Illness (SI)/Intensity of Service (IS) criteria for child and adolescent psychiatric treatment address the following levels of care:

- Inpatient
- Partial hospital
- Alternative services for children, adolescents & their families
- Residential treatment center

- Outpatient psychotherapy

## Severity of Illness (SI) Intensity of Service (IS) Criteria: Child/Adolescent Treatment

In assessing medical necessity of treatment for a given patient, each of the following must be evaluated in a frame work which considers the individuality of the patient:

- Patient's pre-morbid functioning and contrast to baseline posed by this episode of illness
- Degree of danger and threat to life, serious self-harming behavior, destruction of property and assault of others
- Number and severity of stressors in life
- Degree of subjective distress felt by the patient
- Psychopathology and its ego syntonic/dystonic impact on functioning
- The need for psychiatric treatment and evaluation versus the need for control within the penal system

## Inpatient Psychiatric Treatment

Inpatient psychiatric care may be used to treat a mentally ill child or adolescent who requires a 24-hour, medically structured and supervised facility.

### Section D: Child/Adolescent Psychiatric Treatment

EAN's Severity of Illness/Intensity of Service criteria for admission and continued stay at an inpatient facility assume that the patient's illness is so severe that alternative treatment (partial hospitalization, residential, or outpatient) would be unsafe or ineffective and that the patient has the psychological and cognitive capacity to respond to the inpatient treatment program.

## Severity of Illness (SI) Criteria for Admission

A child/adolescent will be considered a candidate for acute inpatient psychiatric treatment if the patient presents with at least one of the following:

- A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, impulsivity, or concurrent intoxication.
- The patient expresses current suicidal ideation and is assumed to be in "real and present danger" (e.g., has plan and means for suicide).

- There is recent history of self-mutilation, significant risk-taking, or other self-endangering behavior.
- Threats of physical harm or behavior have occurred, and there is a clear risk of escalation and repetition of this behavior in the near future.
- There has been destructive behavior towards property which endangers others, such as setting fires.
- Disordered/bizarre behavior or psychomotor agitation or retardation interferes with the activities of daily living to such a degree that the patient cannot function at a lower level of care. \* \*
- A severe life-threatening condition of atypical or unusual complexity has failed to respond to less intensive levels of care and has resulted in substantial dysfunction.
- The patient has a recent history of drug ingestion with a strong suspicion of intentional overdose; such as patient should no longer require intensive medical monitoring but could require treatment of psychiatric and/or substance abuse disorder.
- The patient has experienced severe or life-threatening side effects of atypical complexity from using therapeutic psychotropic drugs.

#### Section D: Child/Adolescent Psychiatric Treatment

- There is severe, sustained, and pervasive inability to attend to age-appropriate responsibilities and/or severe deterioration of family and school function and no other levels of care should be intensive enough to evaluate/treat the disorder\*

*\*\*This does not result from a primary eating disorder. For treatment of Anorexia and Bulimia, see Section F, Eating Disorders.*

*\*This does not imply that most evaluations require inpatient admission or that the hospital is the appropriate setting for ongoing treatment. If the diagnostic picture is clear and there is low risk, another level of care is appropriate. Instead, the criterion is meant to be cited when the patient has put him/herself at actual risk by his/her behavior and treatment cannot be initiated until he or she is contained and assessed. This should be completed in no more than five days. At this point, the patient should be evaluated for ongoing treatment/services. Admissions under the criterion are primarily for the purpose of containment, evaluation, and engaging a child or adolescent in treatment. An example would be the chronic runaway child for whom multiple diagnoses and family stressors must be considered.*

#### Intensity of Service (IS) Criteria for Admission/Continued Stay

If the patient requires at least one of the first five services and number (6) is present, he/she meets IS criteria for admission to an inpatient psychiatric treatment facility:

1. Close and continuous skilled medical observation and supervision to make significant changes in psychotropic medication.
2. Medication or intravenous therapy to modify or prevent life-threatening complications resulting from overdose or withdrawal during detoxification.
3. Continuous observation and control of behavior (e.g., isolation, restraining, and other suicidal/homicidal precautions) to protect property, patient and others.
4. Close and continuous skilled medical observation due to side effects (e.g., hypotension, arrhythmia on psychotropic medication).
5. A comprehensive multi-modal therapy plan requiring close medical supervision and coordination.

AND

6. Evidence of intensive involvement of the family in the therapeutic process.

Section D: Child/Adolescent Psychiatric Treatment

## Psychiatric Partial Hospital Treatment

Partial hospitalization provides stabilization of acute, severe mental illness; therapeutically-supported alternative to inpatient care, threat of chronic illness that is deteriorating, and restoration of patients to a level of functioning that allows them to be safely maintained in the community.

Partial hospitalization may be appropriate when a patient:

- Has acute-stage symptoms
- Does not meet the criteria for 24-hour inpatient treatment, but could require up to 6-8 hours of care up to six times per week
- Needs the availability of psychiatric services up to six days per week

**Partial hospitalization** may also provide supportive transitional services to patients who:

- Are no longer acutely ill
- Require minimal supervision to avoid risk
- Are not fully able to re-enter the family or school arena

## Severity of Illness (SI) Criteria for Partial Hospitalization

A child/adolescent is considered a candidate for admission to, or continued stay in, a psychiatric partial hospital program if the patient presents with at least one of the following:

- 1) Treatment of a psychiatric disorder and co-morbid substance abuse (when present) requires a structured psychiatric setting which can also appropriately treat the substance abuse disorder.
- 2) Suicidal ideation or non-intentional threats or gestures may be present. (Recent suicide attempts, severe hopelessness, or the presence of a well-defined suicide plan would be a relative contraindication for partial hospital care.
- 3) There is recent history of self-mutilation, serious risk-taking, or other self-endangering behaviors.

Section D: Child/Adolescent Psychiatric Treatment

- 4) Threats of physical harm tendencies exist, but do not clearly require a 24-hour protected, controlled or monitored environment.
- 5) There have been destructive fantasies, threats or behavior towards property, which may or may not include behavior that threatens others (e.g., fire setting)  
  
and  
  
there is evidence of patient capacity for reliable attendance at the partial hospital program and compliance with a medication regime, the risk to self, others, or property is not so serious to require 24-hour medical or nursing supervision.
- 6) Disordered or bizarre behavior psychomotor agitation or retardation interferes with activities of daily living to the extent that psychiatric structure and supervision are required for a significant portion of the day.
- 7) A disorder of mood or thought interferes with the ability to fully resume work, family, or school responsibilities unless psychiatric/social/vocational/rehabilitation services are provided.
- 8) As a result of an active psychiatric disorder, the patient is able to maintain adequate nutrition, shelter, or other essentials of daily living only with structure and supervision for a significant portion of the day and with family/community support when away from the partial hospital program.
- 9) The patient has experienced side effects of atypical complexity resulting from psychotropic drugs.

- 10) There is severe, sustained, and pervasive inability to attend to age-appropriate responsibilities and/or severe deterioration of family and school functioning requiring structured psychiatric programming.

## Intensity of Service (IS) Criteria for Psychiatric Partial Hospitalization

If at least one of the following conditions is met, the patient satisfies IS criteria for admission or continued stay in a partial hospital program:

- 1) Routine medical observation and supervision are required to effect significant regulation of psychotropic and/or other medication.

### Section D: Child/Adolescent Psychiatric Treatment

- 2) Routine nursing observation and behavioral interventions are needed to maximize patient functioning and minimize risks to self, others and property.
- 3) Routine medical observation and supervision are necessary to minimize serious side effects (e.g., hypotension, arrhythmia) of medication or to maximize medical management of co-existing medical conditions.
- 4) A comprehensive, multi-modal treatment plan requiring medical supervision and coordination is required because:
  - a treatment plan formulated during inpatient hospitalization has enabled the patient to function without continuous observation and supervision, but not at the outpatient level,

or

- in the absence of partial hospital care, the patient would require admission to full inpatient care, (e.g., acute partial hospital care functions as an alternative).

## Alternative Services for Children/Adolescents and their Families

By the time the child or adolescent behavior becomes disturbed enough to warrant consideration of hospitalization or placement, there has been a history of failed outpatient interventions. Sometimes these have been directed only to the identified patient, overlooking the family system.

At these points of crisis, alternative services may offer the most cost-effective and clinically sound alternative delivery system for the family unit. Originally developed in the public sector in community and regional mental health, such programs provide connected services which can be centered around the client family, rather than forcing them to fit in to traditional treatment options. Some or all of the following elements may be part of an alternative program:

- o 24-hour intake availability, often with a "crisis team" for in-home assessment and stabilization efforts
- o diversion from inpatient hospitalization

- ability to rapidly move a client to more or less intensive services either through the agency's own programs and staff or through community "linkages" with like-minded facilities

#### Section D: Child/Adolescent Psychiatric Treatment

- continuum of services: inpatient, partial hospitalization, respite care, therapeutic foster home home-based services, case management to mobilize community resources or obtain professional services
- total duration of intensive services ranging from several to ninety days (norm is 30 days)

### Severity of Illness (SI) Criteria for Alternative or Home-Based Intensive Services for Children/Adolescents

All of the following must be present:

- 1) Services must be delivered in the home and in the community, with focus on the family systems, and
- 2) Case management, multi-modal services, crisis response capabilities are provided under the direct supervision of the EAN qualified or credentialed mental health professionals and,
- 3) Management of continuum of care is required for effective treatment.

*Note: If a child or adolescent is admitted to a partial or inpatient hospital program during these services, the CCM will apply specific criteria for those levels of care.*

### Certifying Continuing Services

Subsequent certification may be made if all of the following apply:

- The patient and family are fully participating in the treatment services.
- The patient and family are not yet stable enough to be reliably maintained with less intensive outpatient services.
- Progress towards goals set at intake is evident.

Section D: Child/Adolescent Psychiatric Treatment

## Residential Treatment Center (RTC)

Residential treatment centers (RTC) are settings that provide active treatment through specialized programming developed and implemented by mental health professionals. RTC's use community resources for planned, purposeful, and therapeutic activities and allow the residents some degree of autonomy. Treatment at the RTC is less restrictive than inpatient treatment and more restrictive than partial hospitalization or outpatient treatment.

The ideal candidates for RTC treatment seem to be children with personality disorders who nevertheless demonstrate some capacity for object attachment and the potential to contain unacceptable behavior when offered consistency, peer or adult modeling, and positive reinforcement/negative consequences. A family which maintains a commitment to the child despite an intolerable breakdown is an important predictor of a good clinical outcome.

Children and adolescents are separated from day-to-day contact with their families, peers, communities and schools, and therefore RTC's should only be used when all adequate outpatient approaches have been tried. RTC placement should never be used to separate a child from an abusive or neglectful family, or in the absence of family commitment to change.

## General Guidelines for the Use of Residential Treatment Centers

- A complete psychiatric and substance abuse evaluation is required prior to admission.
- RTC placements should be made as close as possible to the home to which the child will be discharged. If out of area placement is unavoidable, there must be a family and facility commitment to assure regular visits to and other contacts with the RTC. Active liaison must be established between the RTC clinical staff and the community-based clinician who will treat the family during and after the placement.

Section D: Child/Adolescent Psychiatric Treatment

- First review of continued stay will occur within fourteen days of admission upon receipt to the Master Treatment Plan from the facility. At this time, any questions the CCM has as to the time frame, specificity of goals, or treatment/discharge plans should be addressed.
- Stay should not generally be extended solely because of failure to achieve goals within expected time frames.
- Planning should begin from admission for reintegration into the family, community, and the school, which should be objectively involved in the discharge planning process. If discharge will not be to the family, active preparation should also begin at admission. The RTC should commit to provide transitional services.
- Continued stay will not be approved primarily to accommodate the school calendar.
- Whenever possible, the child or adolescent should be in public school in the community.
- Failure of the parents to involve themselves in active treatment and to arrange frequent visits at the RTC and at home will raise questions of medical necessity.
- Referrals to Child Protective Services agencies are the responsibility of the RTC personnel.
- An RTC should provide all basic services including psychotherapy within its fee structure and staffing. There must be psychiatric involvement in the assessment and planning process, including a mental status examination and consideration of medication. Regular psychiatric involvement must be demonstrated in treatment planning throughout the stay.
- RTC stays that are used primarily to protect a child from an unstable family environment or to provide special education cannot be considered medically necessary. Alternative resources may be considered when any of these needs exists.
- The need for RTC placement must be differentiated from the need for management within the juvenile justice system.

#### Section D: Child/Adolescent Psychiatric Treatment

### Severity of Illness (SI) Criteria for Residential Treatment Center

A patient meets SI criteria for RTC when ALL of the following are present:

- 1) The patient is able to function with some independence and participate in community-based activities structured to develop skills for functioning outside of a controlled psychiatric environment.

- 2) The patient's primary disorder and behaviors are solely a result of current substance abuse/dependence and the patient is not in need of acute detoxification from any substances.
- 3) The patient shows significant, pervasive dysfunction which has failed to respond to an adequate course of outpatient interventions, including home-based alternatives, where available.

Or

A reasonable course of active treatment in an acute care setting has resulted in an acceptable degree of clinical stability except that maintaining the degree of stability achieved will require a 24-hour structured, supervised setting, with consistent therapeutic intervention from staff in order to maintain an acceptable level of functioning.

- 4) the patient and family demonstrate chronic dysfunction which may respond to multi-modal, psycho educational efforts and systemic interventions, and all parties commit to active, regular treatment participation.

## Intensity of Service (IS) Criteria for Residential Treatment Centers

If all the following conditions are met, the patient satisfies IS criteria for RTC:

- 1) Medical and psycho educational interventions are provided by a multi-modal team composed of qualified mental health professionals and trained child care staff.
- 2) The facility has the capacity to safely restrain and contain an individual during a crisis, but is an open setting.
- 3) Residents will attend community schools and participate in after school and weekend activities in the community. When this is not possible, the RTC will provide these opportunities on grounds.
- 4) All interventions will be focused on re-integration of the child into the family or discharge to a pre-determined alternative living situation.

# Section E:

## Outpatient Psychotherapy

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Section E: Outpatient Psychotherapy

### Outpatient Psychotherapy

EAN has based these criteria for outpatient psychotherapy upon survey of research literature concerning dose-related effects of psychotherapy and upon a consideration of various models of psychotherapeutic change. EAN does not intend to exclude any model from possible consideration for patient care. The guidelines below reflect EAN's belief that outpatient treatment must consider time and cost as legitimate parameters of effectiveness. Specific goals for change should be behaviorally reinforced. Medical necessity requires treatment be delivered in the most cost-effective manner consistent with quality outcome.

In considering whether outpatient psychotherapy is medically necessary under the benefits plan, the CCM should also consider alternatives, such as the use of self-help groups or referral for EAP services since these are available without cost to the beneficiary.

## Situations for Which Outpatient Psychotherapy May Not Be Medically Necessary

Outpatient psychotherapy may not be medically necessary if:

- The individual's GAF is above 70
- Treatment is not voluntary
- The risk of self harm or harm to others is significant and requires significant observation and control
- The individual is actively abusing drugs or alcohol, and cannot reliably contract for abstinence while attending sessions
- The individual lacks the cognitive or expressive capabilities to participate in the behavioral change process
- An active psychotic process interferes with the individual's capacity to maintain a working therapeutic alliance
- Antisocial or other personality traits make it impossible for the patient to accept responsibility for his or her actions, have realistic awareness of the needs and feelings of others, or psychologically adapt to the therapeutic demands for behavioral change

### General Guidelines for Outpatient Psychotherapy

- Except in extraordinary and pre-certified circumstances there must be a direct face-to-face contact between the therapist and patient

### Section E: Outpatient Psychotherapy

- Documentation should reflect a thorough patient/family assessment at the start of treatment, including consideration of risk factors. As treatment proceeds, notes should reflect movement towards measurable goals. Changes in the diagnosis or treatment plan should be substantiated in the medical record.
- A plan for termination must be made after the assessment phase and should be reviewed regularly. A time frame for ending treatment is one requirement for certification of continued treatment for medically necessary services.
- Referral for psychiatric consultation for medication will be made in a timely manner, and the psychotherapist will collaborate with the pharmacotherapist, as required by the patient's specific needs.
- Individual therapy sessions should ordinarily be at least 30 minutes. Medication management may be of shorter duration.
- Individual couple therapy sessions are no longer than one hour, and should be reviewed with the CCM prior to being provided (e.g., emergency, crisis intervention).

- Group sessions are generally 60-90 minutes in length.
- Only one provider may render individual psychotherapy services to the patient. If another clinician provides additional psychotherapeutic services to a member of the same family, both providers must collaborate on treatment planning.
- Significant other persons in the patient's life should be seen as collateral contacts, rather than as separate patients. The billing for these sessions should continue to be in the name of the patient. Although EAN discourages the practice, if a therapist is treating two members of a family individually, the treatment plan should be clinically justified and billed separately. Each individual must meet criteria for DSM-IV diagnosis and for outpatient psychotherapy.
- When more than two members of a family require outpatient psychotherapy, the provider must refer one or more of the family members to another clinician, or use a systems approach to treat the family as a unit.
- Group therapy sessions usually consist of four to ten patients. Multi-family or multi-couple groups may be larger. Groups are to have a stable composition, whether time limited or open ended.

#### Section E: Outpatient Psychotherapy

- Psychotherapy should not be rendered within 24-hours of ECT, or if the patient is significantly cognitively impaired for a longer duration.

### Severity of Illness (SI) Criteria for Problem-Focused Treatment

**All** must be present:

1. Identified problem statement
2. Problem could be resolved by action on the environment or the interaction between the patient and the environment within 1 and 10 sessions
3. Patient can take action with minimal guidance and support

### Intensity of Service (IS) Criteria for Problem-Focused Treatment

1. Face-to-face encounter
2. Concrete problem identification and action plan
3. Assessment for further case identification

4. Rule out need for more intense levels of service
5. Assessment and mobilization of environmental resources
6. Clear documentation of all encounters, assessments, treatment plans and interventions

Problem-focused treatment may occur for up to 10 visits. If satisfactory resolution cannot be anticipated within 10 sessions, one of the following decisions must be made:

- Patient referred for symptom-focused treatment
- Patient referred to a continuing support group or other community resource
- Long-term problem identified for approval for complex case treatment requested
- Individual, couple or family constellations may be seen regularly or as needed
- Patient may not be amenable for treatment

Section E: Outpatient Psychotherapy

## Symptom-Focused Treatment

Symptom-focused approaches are brief treatments which target symptoms resulting from maladaptive thoughts, feelings and/or interpersonal disturbances. Interventions will focus on the presenting symptoms and complaints that have led to a decrease in the patient's usual level of functioning.

### Severity of Illness (SI) Criteria

**All** must be present:

1. Generally short duration (3-6 months) from onset of problems or precipitants, although long-standing problems might be amenable to this approach.
2. The patient has an adequate support system in place or exhibits willingness to develop such a system.
3. The patient's problems are not primarily susceptible to resolution through environmental manipulation or the patient resists this recognition.
4. GAF below 65.
5. The patient has intact cognitive abilities, can assume responsibility for behavioral change, and is capable of developing coping skills for long-term problem solving.

6. Patient is motivated for change.
7. In chronically mentally ill patients, the problem is episodic.

## Intensity of Service (IS) Criteria for Symptom-Focused Treatment

1. Treatment plan must:
  - a. Identify the behaviors that are the target for change.
  - b. Identify the specific interventions to be used.
  - c. Specify treatment length.
2. Treatment can occur in 1-20 sessions.
3. Complete documentation of all encounters, assessment treatment plans and interventions.

### Section E: Outpatient Psychotherapy

4. Evaluate need for medication assessment in the first three (3) sessions.
5. Substance abuse evaluation with referral when appropriate.
6. Individual, couple or family constellation may be seen regularly or as needed.

## Therapeutic Stabilization

The patient requires scheduled or intermittent contact with a clinical professional to maintain his or her level of functioning and to prevent the use of more intensive levels of care. Patients who require the ongoing contact with a therapist should be considered for the most cost-effective approach to chronic management, including medication groups, "as needed" availability of the same therapist as a consistent object during crises, or flexible, discontinuous scheduling which individualizes the patient's need for contact.

## Severity of Illness (SI) Criteria for Therapeutic Stabilization

A patient who satisfies criteria (1) or (2) and (3) meets SI criteria for Therapeutic Stabilization:

(1) The individual has a chronic affective illness, schizophrenia, or a refractory personality disorder, which, by history, has required periodic hospitalization.

or

(2) A disorder of mood or thought interferes with the ability to resume work, family or school responsibilities, unless psychiatric/social/vocation/rehabilitation services are provided

and

(3) The individual is not actively suicidal and/or homicidal and is able to maintain adequate nutrition, shelter and other essentials of daily living with the help of a supportive therapeutic relationship.

## Intensity of Service (IS) Criteria for Therapeutic Stabilization

A patient who requires all of the following meets IS criteria for therapeutic stabilization:

- 1) Face-to-face encounter

### Section E: Outpatient Psychotherapy

- 2) Flexibility in scheduling of outpatient sessions; sessions should not be scheduled more frequently than every two weeks (except during a crisis).
- 3) There should be ongoing efforts to develop family or surrogate support systems.
- 4) Hospital or partial hospital can be used short-term for life threatening, severe crisis stabilization.
- 5) Psychotherapeutic goals are focused primarily on achieving and maintaining stabilization of mood and behavior.
- 6) Psychosocial goals are focused on increased stabilization of the life course (e.g., maintain activities of daily living, increased appropriate interpersonal contact and structure).
- 7) Clear documentation of assessment, treatment plan, progress notes and interventions.
- 8) Up to 26 sessions can occur over a one-year period.

### Outpatient Medication Management

Medication management is the term applied to situations where the sole service rendered by a qualified physician is the evaluation of the patient's need for psychotropic drugs, the provision of a prescription, and ongoing medical monitoring. Interactive psychotherapy is not being rendered at this time by the physician, but may be provided by another clinician. Medication management is specifically classified in one of two categories:

- Providing medical supervision and prescribing or evaluating the need for psychotropic drugs to a patient who is in treatment with a non-medical psychotherapist.

or

- Providing medical services, including prescription of psychotropic drugs, to patients currently not in need of psychotherapy.

Following the initiation of a medication strategy, failure to progress on medication alone or some combination of medication/psychotherapy after 2-3 month trial may require a second opinion regarding the medication.

## Section E: Outpatient Psychotherapy

In certain cases, medication management will continue beyond the psychotherapy component of treatment. In other cases, medication management will occur in the context of long term supportive psychotherapy (usually on a monthly basis). In the authorization of medication management, consideration should be given to the following: the need to involve the family or social support network in order to evaluate compliance with medication regimes as prescribing the medications also providing some aspect of supportive therapy on a regular basis. (Generally, with a patient who is psychologically stable, medication alone can be followed on a 15 minute to 30 minute basis; no more than monthly).

**Severity of Illness (SI) Criteria** (when medication management is the only service being provided).

The patient meets SI criteria for medication management if:

- 1) The patient needs to be evaluated for medication, or to obtain a prescription, or to be medically monitored.

## Intensity of Service (IS) Criteria

The patient meets IS criteria for medication management if:

1. The medication or other medical service is prescribed by a qualified physician, preferably a psychiatrist (non-psychiatrist where psychiatrist is not available, e.g., rural areas).
2. The physician providing the prescription or medical service is not the patient's therapist. (If physicians providing medication management are also providing psychotherapy, the services are more appropriately certified under one of the other treatment models).
3. The physician meets with the patient, face-to-face, on a scheduled basis:
  - **Acute patient.** The physician sees the patient up to once or twice a week if the patient is not yet stabilized on medication or is suffering adverse side effects.
  - **Stabilized/chronic patients.** The physician sees the patient once a month or at least once every three months if the patient's pharmacological plan is appropriate and the patient does not experience complications from medication. Up to 12 visits may be certified over a one year period.

4. The physician collaborates with a psychotherapist (if there is one) when the prescription is renewed or changed.

Section E: Outpatient Psychotherapy

## Complex Case Treatment

Complex case treatment should be considered only for individuals who show significant dysfunction after attempts at problem-focused and symptom-focused approaches have been made. Although a change of therapist will not necessarily be indicated, a shift in case conceptualization should be apparent. Treatment planning should reflect analysis of possible reasons for failure to achieve treatment objectives and goals. The evolving treatment plan should incorporate appropriate interventions to address those issues.

The occurrence of traumatic historical life events in and of themselves is not sufficient for this level of care.

### Severity of Illness Criteria:

A patient who satisfies both criteria below meets SI criteria for Complex Case Treatment:

- 1) GAF below 60
- 2) At least one of the following:
  - Markedly unstable interpersonal relationships, social isolation, self-destructive behavior
  - Recurrent frequent difficulties modulating emotion
  - Disturbances in reality testing
  - Cognitive and behavioral functions are easily and frequently overwhelmed or driven by affect
  - Enduring rigid styles that seriously restrict important life options that would otherwise be available to that person
  - Severe impairment in job functioning/educational performance

### Intensity of Service (IS) Criteria:

A patient must meet all of the following:

- 1) Face-to-face encounter

## Section E: Outpatient Psychotherapy

### 2) Treatment plan must:

- Identify current problems in functioning which provider and patient agree are the goals of treatment.
- Recognize that improvement is contingent upon the patient making changes in his/her own behavior, changes in ways of thinking about or reacting to situations or learning to tolerate unpleasant affect.
- Contain distinct markers of progress and be expected to lead to termination within one year

### 3) Patient must demonstrate:

- Ability to report relevant thoughts, feelings, images
- Ability to take action on the basis of issues discussed in treatment

4) When severe family dysfunction is present, family systems conceptualization should be used. Family members may be treated individually and in differing subgroups, depending on the identified problems. This treatment should be provided in most cases by one therapist.

5) Evaluation of need for medication assessment has occurred.

6) Difficulties in therapeutic relationships do not need to be a major focus treatment.

7) Assess the applicability of intensive care management and implement when indicated.

8) Clear documentation of assessment, treatment plan, progress notes and interventions.

9) Up to twelve sessions can occur over a three month period.

# Section F: Eating Disorders

**E A N**

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Section F: Eating Disorders

Problem Areas in the Diagnosis and Treatment of Eating Disorders

- In DSM-IV, Bulimia is characterized by a pattern of bingeing and purging. This delineation distinguishes bulimics from compulsive overeaters and the morbidly obese, who are sometimes admitted to eating disorder programs and are described as “non-purging bulimics”. Morbid obesity is covered as a medical disorder under some health plans.
- Obesity itself is not a DSM-IV diagnosis, compulsive overeating is neither a medical nor a psychiatric diagnosis and individuals manifesting this behavior are most appropriately referred to established weight loss programs or the Overeater’s Anonymous, a twelve-step program. Few bulimics display a level of acuity which requires 24-hour care.
- Anorectics, on the other hand, can become medically unstable and are more likely to require hospitalization when weight drops too far below Ideal Body Weight (IBW). This may necessitate a medical setting or a specialized eating disorder unit with capacity to manage a high risk medical situation. While patients with eating disorders can be handled on a general psychiatric or a specialty unit, complex cases requiring close monitoring are best dealt with in specialty units. Substance abuse rehabilitation units rarely are capable of handling eating disorder patients ill enough to require hospitalization.
- As with all other care, length of stay and treatment plans should always be individualized. Treatment plans which focus primarily on nutrition, addiction, medication or behavior modification are too narrow to offer adequate and essential treatment to these complex and poorly understood disorders. Family dysfunction, social pressures regarding appearance, intrapsychic conflicts and neuroendocrine regulation are also contributory to eating disorders and must be addressed by appropriate personnel.
- In addition, patients with eating disorders often have a high incidence of co-existing psychiatric illness or substance abuse (especially of stimulants, laxatives, thyroid, diuretics, insulin). Personality disorders of certain types are common, and many eating disorder patients are the “adult children” of substance abusers. Concomitant physical illness further complicates certain cases.

#### Section F: Eating Disorders

- Major depression is often cited as the leading diagnosis for Bulimia admissions. If the patient genuinely has the signs, symptoms and risks associated with major depression, hospitalization on a psychiatric unit should be expected.
- EAN views eating disorders as a primarily psychiatric illness, not substance abuse, although addiction-like behavior may be present and a twelve step approach may be part of the total treatment plan.

*Note: Reimbursement for the inpatient treatment of patients diagnosed solely with an eating disorder (without another DSM-IV diagnosis) may be excluded under the health benefit plan.*

## SI/IS Inpatient Admissions and Continued Stay Criteria for Anorexia and Bulimia

At least one of the following is present:

1. Patient has had a rapid weight loss of 15-25% Ideal Body Weight (IBW) in anorexia of recent onset.

Or

Patient has lost 25% IBW and has chronic impairment of functioning.

Or

Patient has lost less than 25% IBW but has chronic impairment of functioning, significant others who sabotage treatment, and a failure of at least two months of comprehensive outpatient treatment.

2. Medical complications from anorexia threaten life or health. Among the possible complications are:

- Cachexia
- Intestinal atony with obstruction
- Nutritional anemia
- Impaired renal function
- Fluid and electrolyte imbalance
- Cardiac arrhythmia
- Exercise-induced injury

### Section F: Eating Disorders

3. Patient's intake is so restricted that needed medications cannot be reliably, effectively or safely administered.
4. The patient's anorexia has led to the abuse of substances (such as diuretics, amphetamines, emetics, thyroid and insulin) and the abuse cannot be managed on an outpatient basis.

## Intensity of Service (IS) Criteria for Anorexia and Bulimia

The patient requires both:

1. 24-hour medical and nursing supervision for safe or effective treatment; no alternative level of care can be utilized.

And

2. A comprehensive, multi-modal treatment plan that includes:
  - Available medical, dental, and registered dietician services
  - Individualized treatment plan for weight gain or interruption of the binge-purge cycle
  - Nursing assessment and monitoring of eating behavior, including calorie-intake if needed
  - Active psychiatric involvement in daily treatment planning
  - Family assessment and involvement in treatment

## Initial and Continuing Criteria for Intensive Outpatient Treatment of Eating Disorders

### Severity of Illness (SI) Criteria

All of the following apply:

1. The patient does not require 24-hour medical and nursing supervision due to medical complications or concomitant psychiatric disorder.
2. Prior outpatient assessment and treatment have demonstrated that a more comprehensive (multi-modal, multi-disciplinary) approach is required than could be provided through office-based treatment.

## Section F: Eating Disorders

And

3. The patient recognizes that the eating disorder is motivated, and has familial and social supports.

## Intensity of Service (IS) Criteria for Intensive Outpatient Treatment

The following applies:

1. A comprehensive, multi-modal treatment plan is available which includes:
  - Available medical, dental, and registered dietician services

- Individualized treatment plan for weight gain or interruption of the binge-purge cycle
- Nursing assessment and monitoring of eating behaviors
- Active psychiatric involvement in treatment planning

# Section G:

## Psychological Testing

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Section G: Psychological Testing

### Psychological Testing and Services

Psychological testing is utilized to gain systematic and complete samples of various aspects of the patients functioning including perceptual, motor and verbal functioning. Psychological tests provide a more “objective” way to obtain data than more “subjective” methods. Thus, the psychologist’s aim in testing is to produce data and hypotheses from standardized, valid and reliable objective tests and arrange these data into a framework which elucidates the patients’ particular problem(s). This then allows for formulated construct or set of hypotheses to emerge which not only assist in leading to a diagnosis but help toward a treatment solution.

When the clinical case manager or Peer Advisor reviews a request for psychological testing, the review is conducted to determine:

- Are the questions clear and do they fit in the clinical context?
- Will the tests answer the questions?
- Are all tests selected needed?
- What is the time required to complete testing?

*Note: All psychological and neuropsychological testing requires pre-certification except inpatient when testing is included in the negotiated per diem rates.*

## Evaluating the Medical Necessity for Psychological Testing

In evaluating the medical necessity of psychological testing, the following should raise concerns regarding its appropriateness:

- The diagnosis appears clear without testing
- Functional level appears related to evident stressors
- Other sources of the same information are available
- Greater specificity is not necessary for development of treatment plans
- Testing appears to be primarily for educational purposes

Medical necessity for psychological testing can only exist when the following conditions are met:

### Section G: Psychological Testing

- There is significant uncertainty about the appropriate course of treatment for the patient or the patient has not responded to standard treatment with no clear explanation and the results of psychological testing will have a timely effect on the treatment plan. Psychological testing should not be routinely administered as an approach to evaluation, but should be guided by individual routine circumstances; or

Testing is needed for a differential diagnosis:

- This question can be answered most cost-effectively through psychological testing (rather than through continued observation and clinical interviewing, by history, by pragmatic trial or by obtaining prior treatment or testing records); and
- The administration and/or interpretation of the test must require significant time and skill of an appropriately trained and licensed or certified psychologist; and
- When administration of neuropsychological testing is delegated to someone other than a licensed psychologist the report must be reviewed and signed by the supervising psychologist who is responsible for its content; and
- Testing to resolve the same questions has not been administered within the last year unless there is strong evidence that new events have significantly affected the patient's functioning.

Complex psychological testing which requires professional administration and interpretation leads to professional fees. Requests for these separately billed services require pre-certification.

## Neuropsychological Testing

This testing requires highly sophisticated administration and interpretation. Tests evaluate visual and auditory perception, language function, memory and psychomotor function. The goal is to rule out or diagnose brain dysfunction which has behavioral correlation or determine the abilities of a patient known to have organicity.

The features of different organic brain syndrome differ but they are generally characterized by one or more of the following serious disruptions of cognitive or central nervous system functioning:

- Disorientation to time and place
- Fluctuating level of consciousness
- Serious impairment of memory

### Section G: Psychological Testing

- Inability to perform simple calculations or abstract or other serious circumscribed cognitive deficits
- Sensory illusions
- Hallucinations other than auditory
- Problems with body movement and proprioception

Clinical signs which suggest investigation of organic factors include:

- Suggestions of any of the specific brain syndrome deficits listed above
- Head trauma (recent)
- Visual disturbances, double vision, partial loss of vision
- Dysarthria or aphasia
- Abnormal body movement or loss of motor function
- Changes in consciousness
- Sustained deviations in vitals
- Disturbances in instinctual behavior (eating, drinking, sex, aggression)
- Seizure history
- Incontinence

*Note: Mental status exam, history and neurological consult should precede any certification for neuropsychological testing. In addition, all requests for neuropsychological testing require prior approval by an EAN Peer Advisor.*

## Section H:

# Guidelines regarding the use of Electroconvulsive Therapy

# EAN

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Section H: Guidelines for the Use of Electroconvulsive Therapy

## Guidelines Regarding the Use of Electroconvulsive Therapy

Major Indication for Use:

### 1. Major Depression

- Major Depression, single episode (296.2x)
- Major Depression, recurrent (296.3x)
- Bipolar I Disorder, depressed (296.5x)
- Bipolar I Disorder, mixed (296.6x)
- Bipolar II Disorder, not otherwise specified (296.80)

### 2. Mania

- Bipolar I Disorder, manic (296.0x)
- Bipolar I Disorder, mixed (296.6x)
- Bipolar I Disorder, not otherwise specified (296.80)

### 3. Schizophrenia and Other Functional Psychosis

- Psychotic schizophrenia exacerbation in the following situations:
  - Catatonia (295.2x)
  - When affective symptomatology is prominent
  - When there is a history of favorable response to ECT
- Related psychotic disorders
  - Schizophreniform disorder (295.40)
  - Schizoaffective disorder (295.70)

Situations in which ECT may be used prior to trial of psychotropic medication include (but are not limited to):

1. Need for rapid, definitive response on either medical or psychiatric grounds
2. Risks of other treatments outweigh the risks of ECT
3. History of poor drug response and/or good ECT response for previous episodes of the illness
4. Patient preference

#### Section H: Guidelines for the Use of Electroconvulsive Therapy

After a trial of an alternative treatment, referral for ECT should be based on at least one of the following:

1. Treatment failure
2. Adverse effects which are unavoidable and which are deemed less likely and/or less severe with ECT
3. Deterioration of the patient's condition such that there is a need for rapid, definitive response on either medical or psychiatric grounds

#### Contraindications and Situations Associated with Substantial Risk

1. "Absolute" contraindication
  - None
2. Situations associated with substantial risk:
  - Space-occupying cerebral lesion or other condition with increased intracranial pressure
  - Recent myocardial infarction with unstable cardiac function
  - Recent intracerebral hemorrhage
  - Bleeding or otherwise unstable vascular aneurysm or malformation
  - Retinal detachment
  - Pheochromocytoma
  - Anesthetic risk rated at ASA level 4 or 5

#### Adverse Effects

1. Cognitive dysfunction: consider treatment modifications if symptoms are problematic:
  - Change from bilateral to unilateral right electrode placement
  - Decrease the intensity of electrical stimulation
  - Increase time interval between treatments
  - Alter the dosage of medications

- Terminate the treatment course, if necessary

#### Section H: Guidelines for the Use of Electroconvulsive Therapy

2. Cardiovascular dysfunction
3. Prolonged apnea
4. Prolonged seizures (more than 180 seconds)
5. Treatment emergent mania
6. Adverse subjective reactions by patients or their families

#### Consent for ECT: The consent document should include the following:

1. A description of ECT procedures including:
  - When, where and by whom the treatments will be administered
  - A range of the number of treatment sessions likely
  - A brief overview of the ECT technique itself
2. A statement of why ECT is being recommended and by whom, including a consideration of reasonable treatment alternatives (an internal second opinion, where applicable)
3. A statement that, as with any treatment modality, the therapeutic (or prophylactic) benefits associated with ECT may be transient
4. A statement as to the likelihood and severity of risks related to anesthesia, muscular relaxation and seizure induction, including: mortality, cardiac dysfunction, confusion, acute and persistent memory impairment, musculoskeletal and dental injuries, headaches and muscle pain;
5. An acknowledgment that, as with any other procedure involving general anesthesia, consent for ECT also implies consent to perform appropriate emergency medical interventions in the unlikely event this proves necessary during the time patient is not fully conscious
6. An acknowledgment that consent is voluntary and can be revoked at any time before or during the treatment course
7. A statement that the Consenter is encouraged to ask questions at any time regarding ECT, and whom to contact for such questions

## Section H: Guidelines for the Use of Electroconvulsive Therapy

8. A description of any restrictions on patient behavior that are likely to be necessary prior to, during or following ECT

### Use of ECT in Special Populations

#### 1. Children and Adolescents

- If 12 or under, ECT is reserved for instances in which other treatments have not been effective or cannot be safely administered.
  - Concurrence provided by two psychiatrists not otherwise involved with the case and experienced in the treatment of children including somatic therapies. They must review the record, interview the patient and discuss the case with the attending physician and parent/guardian.
  - Anesthetist for ECT experienced in anesthetic procedures with children of this age.
- For adolescents, concurrence procedure same as for children 12 or under except concurrence by a single psychiatrist with substantial experience treating adolescents, including somatic therapies.

#### 2. The Elderly

- May be used with the elderly, regardless of age.
- Efficacy does not diminish with advancing age.
- May be generally less risky than pharmacotherapy, although cardiovascular and skeletal risks should be carefully evaluated.
- Dosages of anticholinergic, anesthetic and relaxant agents may need modification on the basis of physiologic changes associated with aging.
- The stimulus intensity should be selected with the awareness that seizure threshold generally increases with age.
- Decisions regarding ECT technique should be guided by the possibility that ECT-induced cognitive dysfunction may be greater in the elderly.

#### 3. Pregnancy

- May be used in all three trimesters of pregnancy.
- Teratogenic risks (up to 8 weeks gestational age) should be noted in the informed consent process.
- Obstetrical consultation prior to ECT.
- Noninvasive monitoring of fetal heart during each ECT treatment session and recovery period is encouraged when gestational age is over 10 weeks.

## Section H: Guidelines for the Use of Electroconvulsive Therapy

- Additional monitoring and the presence of an obstetrician at the time of ECT may be indicated in high risk cases or when pregnancy is close to term.
- Ready access to means of managing fetal emergencies.

### 4. Concurrent Medical Illness

- Consider anticipated effects of patient's medical status upon risks and benefits of ECT.
- Consider pertinent laboratory tests and specialist consultation, when indicated.
- Consider modifications of ECT procedure to lower potential morbidity and/or augment efficiency.

## Pre-ECT Evaluation

1. Psychiatric history and examination to determine the indication for ECT. The history should include an assessment of the effects of any prior ECT.
2. A medical evaluation to define risk factors (including medical history, physical examination, vital signs, hematocrit and/or hemoglobin, serum electrolytes and electrocardiogram).
3. Anesthesia evaluation, addressing the nature and extent of anesthetic risk and advising of the need for modification in ongoing medications and/or anesthetic technique.
4. Informed consent.
5. An evaluation by an individual privileged to administer ECT (Treating Psychiatrist), documented in the clinical record by a note summarizing indications and risks, and suggesting any additional evaluative procedures, alterations in ongoing medications, or modifications in ECT technique that may be indicated.

## Use of Psychotropic and Medical Agents During ECT Course

1. Agents that increase morbidity or decrease the efficacy of ECT should be discontinued or decreased prior to ECT as risk-benefit considerations allow.

## Section H: Guidelines for the Use of Electroconvulsive Therapy

- Benzodiazepines

- Most other sedative hypnotics
  - Anticonvulsants
  - Lidocaine and its analogues
  - Reserpine
  - Lithium
  - Theophylline
2. In general, it is advisable to discontinue psychotropic agents prior to ECT, although this should not prevent the institution of treatments on a timely basis.
    - Low to moderate doses of neuroleptics with ECT may sometimes be helpful early in the treatment course for patients with psychosis.
    - For monoamine oxidase inhibitors, an appreciable drug-free period is not necessary prior to ECT.

## Number of Treatments

1. The total number should be a function of the patient's response and the severity of adverse effects.
2. An ECT course generally consists of 6-12 treatments, performed every other day.
  - Larger numbers may be indicated when:
    - Change in ECT technique due to lack of response.
    - Some patients (e.g., with schizophrenia) may require more treatments to achieve a desired level of response.
3. For patients who respond to treatment, ECT should be terminated as soon as it is clear that maximum response has been reached (i.e., positive changes in target symptoms).
4. If no discernible clinical improvement after 6-10 treatments, indication for continued ECT should be reassessed.
5. Repeated courses of ECT are sometimes necessary.

## Section H: Guidelines for the Use of Electroconvulsive Therapy

### Evaluation of Outcome

1. Therapeutic response
  - Each treatment plan should indicate specific criteria for remission

- Clinical assessment should be performed by the Attending Physician or designee and documented prior to ECT and after every 1-2 ECT treatments, preferably on the day following the treatment

## 2. Adverse effects

- Cognitive status should be consistently monitored and documented:
  - Prior to beginning ECT.
  - At least weekly throughout a course of ECT. Assessment should be performed when possible at least 24-hours following ECT treatment.
  - If substantial deterioration, modification of ECT procedures should be considered.
  - If substantial effects remain several days following completion of ECT, a specific plan for post-ECT assessment and intervention is medically indicated.

## Documentation

1. Prior to a course or series of ECT, the following should be documented:
  - Reasons for ECT referral, including an assessment of anticipated benefits and risks
  - Mental status, including baseline information pertinent to later determination or therapeutic outcome, as well as cognitive and memory functions
  - Signed consent document
  - A statement covering other elements of the informed consent process as described in the section, Consent for ECT
  - A summary of the pre-ECT evaluation
  - Consultation reports, as indicated
  - A discussion of any planned alterations in the ECT procedure
  - A justification for outpatient ECT, if applicable

## Section H: Guidelines for the Use of Electroconvulsive Therapy

### 2. Between ECT Treatment Sessions

- Notes by Attending Physician or designee, following each session
- Notes by the above to include:
  - Assessment of therapeutic outcome
  - Adverse effects
  - Justification for continuation of ECT, where indicated, by number of treatments or duration of continuation or maintenance of ECT

### 3. At time of each ECT treatment session, the following should be documented:

- Baseline vital signs
- Medications given prior to entry into the treatment room, including dosage
- A note by the anesthetist concerning the patient's condition during the time he/she remains in the treatment area
- Where applicable, a note by the treating psychiatrist or anesthetist covering any major alterations in risk factors or presence of adverse effects or complications, including actions taken and recommendations made
- All medication given in the treatment or recovery area, including dose
- Stimulus electrode placement
- Stimulus parameter settings
- Seizure duration (noting whether motor or EEG)
- Vital signs taken in treatment room and recovery area