Psychiatric Residential Treatment - Children, Adolescents and Adults

Date of Origin: 04/2008 **Last Review Date: 10/23/2024** **Effective Date: 11/1/2024**

Dates Reviewed: 04/2010, 05/26/2010, 05/2011, 05/2012, 05/2013, 05/2014, 05/2015, 07/2016, 07/2017, 07/2018, 07/2019, 10/2020, 9/2021, 10/2022, 10/2023, 10/2024

Developed By: Medical Necessity Criteria Committee

I. Description

Residential treatment is defined as a 24-hour level of care that provides a range of diagnostic and therapeutic behavioral health services that cannot be provided in an outpatient setting. Research strongly suggests that the best therapeutic environment is one that is both safe and least restrictive to the patient. Admission to this level of care should be made only after a face-to-face interview and assessment with the patient and family members and only with clinical evidence of the failure of all available and appropriate outpatient interventions or documentation of why such interventions are either unavailable or reasonably expected to be insufficient to meet the member's needs. Placement in residential treatment is appropriate if the member does not need the higher level of physical security and frequency of psychiatric and nursing interventions that are available in a psychiatric hospital. Although it is sometimes assumed that residential care implies a longer length of stay than inpatient care, studies have shown that residential care is an efficacious short-term alternative to inpatient care for voluntary patients with urgent behavioral health conditions.

If residential treatment is indicated, placement should be in a facility closest to the patient's home at discharge. If out-of-area placement is the only appropriate option, there must be facility and family commitment for regular and ongoing participation of family in treatment. In addition, contact should be established as early as possible between facility and community-based professionals who will be treating patient and family after discharge from the residential setting.

Notes:

1. Effective 1/1/2023, Moda Health uses Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care (CALOCUS), and Early Childhood Service Intensity Instrument (ECSII) to make level of care determinations for Oregon-based commercial plans.
2. Therapeutic boarding schools" and "wilderness treatment programs" often do not meet minimum program requirements for residential programs.
3. The following criteria are intended as a guide for establishing medical necessity for the requested level of care. They are not a substitute for clinical judgment and should be applied by appropriately trained clinicians giving consideration to the unique circumstances of each patient, including co-morbidities, safety and supportiveness of the patient's environment, and the unique needs and vulnerabilities of children and adolescents.

II. Criteria: CWQI BHC-0011

Oregon-based Commercial Plans:

The ECSII, CALOCUS, and LOCUS are standardized tools used to determine the intensity of treatment services and level of care needed. The ECSII is used for children ages 0-5. The CALOCUS is used for children and adolescents ages 6-18. And the LOCUS is used for adults ages 18 and up. When using the LOCUS/CALOCUS/ECSII, psychiatric residential treatment is considered Level Five – Medically Monitored Residential Services. Level Five is indicated with a CALOCUS composite score of 23-27, a LOCUS composite score of 24+, or an ECSII score of 27-30 (or a lower score, adjusted per ECSII instructions).

A. Per ECSII, Clinical Services should include:

"treatment 24 hours a day and can serve children and adolescents with serious emotional disturbances receive constant supervision and care. Programs may serve 12 or more young people at a time. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization."

B. Per CALOCUS, Clinical Services should include:

1. The primary clinician should review the child or adolescent's progress daily and debrief back-up staff as needed.
2. Child and adolescent psychiatrists are integral members of the treatment team and, if not the primary mental health clinician, serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation.
3. Psychiatric care should be available on-site at least weekly, client contact may be required as often as daily. Acute populations requiring 0.5-1.0 hours/week.
4. Individual, group, and family therapy. Substance abuse services may be available.
5. Primary medical care should be an accessible, integrated part of the comprehensive array of services.
6. Non-psychiatric clinical services generally average 8-20 hours/week.
7. Treatment should be family-centered. The goal of treatment for children or adolescents in out-of-home placements should be a timely return to the family and community.
8. Transition planning should be considered in daily clinical review.

C. Per LOCUS, Clinical Services should include:

1. Access to clinical care must be available at all times.
2. Psychiatric care should be available either on-site or by remote communication 24 hours daily and psychiatric consultation should be available on-site at least weekly, but client contact may be required as often as daily.

3. Facilities serving the most acute populations will require 0.5 to 1.0 hours of psychiatric time per client per week.
4. Emergency and ongoing medical care services should be easily and rapidly accessible, preferably available on-site and/or integrated with the treatment team.
5. On-site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis.
6. On-site treatment should be available seven days a week including individual, group, and family therapy.
7. Non-psychiatric clinical services generally average 8-20 hours per client weekly.
8. In addition, rehabilitation and educational services must be available either on or off-site.
9. Medication is monitored but does not necessarily need to be administered to residents in this setting.

Non-Oregon-based Commercial Plans

A. Clinical Services should include ALL of the following:

1. Facility holds licensure and/or accreditation for the level and type of care provided and is practicing within the scope of its license. Facilities in Oregon must be licensed under chapter 309 of Oregon Administrative Rules.
2. 24-hour supervision by mental health treatment staff, including at least one nurse onsite or on call at all times, to assist with medical issues, crisis intervention, and medication.
3. Staff must have the ability to safely restrain and protect individuals during a crisis for the safety of the patient and others. Not applicable to adult-only programs.
4. Patient must be staying overnight at the facility.
5. Patient must be involved in a structured treatment program for at least 8 hours per day, 5 days a week under the supervision of a licensed mental health professional, consisting of **ALL** of the following, tied to goals described in the individualized treatment plan:
    a. Documentation of the individual's participation in each treatment activity;
    b. Group therapy at least daily. Groups are therapeutic and tied to the individual's treatment plan goals.
    c. Individual therapy with a primary therapist at least twice per week;
    d. Family therapy at least once per week. If this is not possible or indicated, clinical evidence must be given and an acceptable alternative offered; Family therapy is more than updating parents on their child's status/progress.
    e. Individualized case management activities as needed;
    f. Structured skills training, vocational training, education, recreation, and/or socialization activities. These activities must be tied to the individual's treatment plan.
6. Initial Treatment plan meets ALL of the following:
    a. Is completed within 7 days of admission;
    b. Is individualized, not determined by programmatic duration;
    c. Includes an appropriate mix of modalities (i.e. family, group, and individual therapies);
    d. Addresses the specific problems leading to the admission.
7. Regular psychiatric involvement, including evaluation within 72 hours of admission. Once

weekly review by a psychiatrist or psychiatric nurse practitioner occurs until discharge along with ongoing medication monitoring.

8. Aftercare treatment planning for the reintegration of the patient into the home, school, and community.

B. **Admission Criteria:**

Authorization for admission is indicated by **ALL** of the following:

1. Patient does not meet criteria for acute inpatient mental health treatment.
2. Patient has an active psychiatric diagnosis which requires therapeutic intervention.
3. The patient is medically stable.
4. The patient cannot be treated safely and effectively at a lower level of care due to **1 or more** of the following:
    a. Serious and persistent psychosocial impairments that have failed to respond to treatment at all appropriate lower levels of care, or documentation of why such treatments are reasonably expected to be insufficient to meet the member's needs. (Note: Non-participation does not constitute failure at a lower level of care);
    b. Danger to self or others;
    c. Profound role failure; or
    d. The appropriate lower level of care is not reasonably available to the patient.
5. The patient is judged physically and cognitively able to actively participate in treatment.
6. For recent readmissions, the treatment plan clearly states what will be done differently to address risk factors that led to the readmission and promotes increased use of skills to support a successful transition to a lower level of care.
7. Discharge planning, including coordination with established outpatient providers, begins at the time of admission.

Continued Care Criteria: Continued authorization is indicated by **ALL** of the following:

1. The treatment plan focuses on resolving the difficulties appropriate to this level of care.
2. Clinical evidence of engagement in treatment and the ability to achieve the treatment plan goals.
3. Active involvement of parents/caregivers/family members in treatment unless contraindicated.
4. Patient is making progress toward resolving the problems appropriate to this level of care, a recent treatment plan change is reasonably expected to resolve a lack of progress.
5. Patient has not improved enough to be safely and effectively treated at a lower level of care.
6. Ongoing involvement of established outpatient providers in discharge planning, or efforts to establish an outpatient provider are actively underway.

Discharge Criteria: Termination of continued authorization is indicated by **1 or more** of the following:

1. Treatment goals appropriate to the residential level of care have been met.
2. The patient's condition has improved to the point where the patient no longer requires 24 hours per day supervision and observation.
3. The patient can be safely and effectively treated at a lower level of care (e.g. mental health partial hospitalization, intensive outpatient or outpatient treatment).
4. The patient's physical condition necessitates transfer to a medical facility.
5. The patient is not making progress at the current setting or level of care (unless a recent treatment plan change is reasonably expected to resolve the lack of progress).

Authorization note:

Moda Health will authorize residential treatment if the next lower level of care is appropriate but not reasonably available. If the patient or family declines an available appropriate lower level of care, or if the residential facility fails to engage in reasonable and appropriate discharge planning, Moda will not authorize residential treatment.

Contra-indications:

1. Running away and disobedience are not in and of themselves sufficient reasons for admission to residential level of care.
2. Readmission or continued stay is expected to be counter-therapeutic due to **1 or more** of the following:
    a. Previous admissions to the same or a similar program have not been therapeutically beneficial;
    b. The patient has reached maximum expected therapeutic benefit from previous admissions or during the current admission;
    c. The treatment reinforces an unhealthy self-image or identification with the illness.
    d. For a patient with attachment disorder, residential treatment would interfere with interventions that are more appropriate to take place in the home environment.

III. Information Required with the Prior Authorization Request:

1. Diagnosis, symptoms, and functional impairment;
2. Relevant biopsychosocial and treatment history;
3. Alcohol and other drug use history, or assessment;
4. Current medical status and relevant medical history;
5. Current medications;
6. Risk assessment;
7. Specific goals for stabilization;
8. Treatment plan;
9. Plan for outpatient follow-up following discharge; and
10. Faxed copy of initial psychiatric evaluation, History & Physical, and/or daily treatment schedule may be required.

VI. Annual Review History

Review Date	Revisions	Effective Date
05/2013	Annual Review. Added table with review date, revisions, and effective date. Minor word changing.	05/2013
05/2014	Annual Review.	05/2014
05/2015	Annual Review. Added description of custodial care and other clarifying language.	05/2015
07/2016	Annual Review. Added least restrictive language, added #2 and #3 contra-indications, updated citation and licensure/accreditation requirements.	07/2016
06/2017	Annual Review. Addressed readmissions. Updated facility licensing requirements.	09/2017

06/2018	Annual Review. Updated accreditation requirements; provided detail regarding structured treatment; clarified factors indicating a lower level of care is not appropriate; clarified contraindications.	08/2018
07/2019	Changed title from "Mental Health Residential Treatment" to "Psychiatric Residential Treatment"; added clarification re: role of and application of criteria; affirmed appropriateness of requested level of care when a lower level of care is not reasonably available; added informational note regarding therapeutic boarding schools and wilderness treatment programs; added clarifications regarding facility requirements; removed requirement for continued treatment that the patient continues to meet criteria for initial authorization; added requirements for family and outpatient provider involvement for continued treatment; additional minor clarifications.	09/2019
10/2019	Corrected typo on discharge criteria D.3. "patient CAN be safely and effectively treated…"	10/2019
10/2020	Corrected references to Oregon Administrative Rules	11/2020
9/2021	Removed requirement for CARF/Joint Commission accreditation for OON facilities. Added statement about authorizing residential care if next lower level of treatment is not reasonably available.	10/2021
10/2022	Re-organized notes in first section. Added note about use of LOCUS, CALOCUS-CASII, and ECSII.	11/2022
10/2023	Annual review. No substantive changes.	11/2023
10/2024	Annual review. Added definitions for CALOCUS, LOCUS, ECSII. Identified clinical services needed for Level 5. Added clarification for which criteria are for Oregon-based commercial plans and non-Oregon-based commercial plans. Added AACP LOCUS reference.	11/2024

VII. References

1. American Academy of Child and Adolescent Psychiatry Practice Parameters, www.aacap.org/index.ww.
2. American Psychiatric Associates Guidelines for Adults, www.apa.org.
3. *Child and Adolescent Psychiatric Care*. City of Philadelphia. 2000.
4. *Criteria for Short-term Treatment of Acute Psychiatric Illness*. American Academy of Child and Adolescent Psychiatry. 1995.
5. *Mental Health Criteria for Hospitalization*. Department of Services for Children, Youth and Their Families, Division of Child Mental Health Services. 2004. State of Delaware.
6. National Guideline Clearinghouse. Guideline Summary NGC – 5511. Guideline Title: Practice Parameter for the assessment and treatment of children and adolescents with bipolar disorder.
7. National Guideline Clearinghouse. Guideline Summary NGC – 5514. Guideline Title: Practice parameter on child and adolescent mental health care in community systems of care.
8. *Oregon Administrative Rules.* Residential Treatment Facilities for and Residential Treatment Homes for Adults with Mental Health Disorders. OAR 309-035-0100 to 309-035-0225. 2020.
9. *Oregon Administrative Rules.* Intensive treatment services for children and adolescents and children's emergency safety intervention specialist. OAR 309-022-0100 to 309-022-0190. 2020.
10. *Oregon Administrative Rules.* Standards for the approval of providers of non-inpatient mental

health treatment services. OAR 309-039-0500 to 309-039-0580. 2020.
11. *Oregon Administrative Rules.* Definitions of Coordinated Care and Case Management for Behavioral Health Care Services. OAR 836-053-1403. 2020.
12. *Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers*. American Academy of Child & Adolescent Psychiatry. 2010.
13. United States District Court, Northern District of California. *David Wit, et al*., *v. United Behavioral Health.* Findings of Fact and Conclusions of Law. 2019.
14. American Association of Community Psychiatrists. *Child and Adolescent Level of Care Utilization System (CALOCUS).* 2010.
15. American Association of Community Psychiatrists. Level of Care Utilization System For Psychiatric and Addiction Services. Adult Version 20. December 2016.