

LEVEL OF CARE AND TREATMENT CRITERIA

Level of Care Criteria

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Standard Definitions

- Custodial Care
- Medical Necessity

Adult Half Day Partial Hospital Treatment

Definition:

Treatment occurs in an ambulatory setting together with full day partial hospitalization using multi-disciplinary treatment approaches that include coordinated, intensive, comprehensive modalities, and medical supervision. Treatment is provided in up to 4 hours daily, but will access the same resources and milieu as standard PHP. It is designed for patients with active mental disorders who require more medical supervision than traditional structured outpatient programs can provide.

Comment:

1. *Half-day PHP can serve as a step down treatment modality for patients who are doing well in the full day PHP, are taking full responsibility for their treatment and are preparing to transition to regular outpatient care.*
2. *It may be used as more comprehensive treatment than an IOP for those patients who do not require up to 8 hours per day of treatment. It is different from IOP in that it utilizes the full spectrum of services available in the PHP setting, including more intense medical scrutiny.*
3. *The following guidelines are suggested for an individualized half-day partial hospitalization treatment plan as clinically indicated:*
 1. *Individual psychotherapy daily.*
 2. *Group psychotherapy daily.*
 3. *Family psychotherapy 2X/week.*
 4. *Milieu therapy daily.*
 5. *Substance Use Disorder - 12 step group (when indicated) 2X/week.*
 6. *Medication management (when indicated) daily.*

Admission Criteria - Requires ALL:

1. Patient will have a DSM IV-TR Axis I diagnosis (other than a V-code except as specified by plan designs).
2. The patient is experiencing moderate to severe symptoms and/or functional impairment(s).
3. The patient can be safely and effectively managed in a Partial Hospital setting without significant harm to self/others and decompensation.
4. The patient requires up to 4 hours of intensive and structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group or family therapy, education and medical supervision.
5. The patient's condition requires more intensive medical supervision and contact than would be available in an IOP.
6. The patient's environment, living situation and social support system are sufficiently stable to allow for treatment in this care setting.
7. The patient's functional capacity (e.g., cognitive, behavioral) is high enough to allow for meaningful participation in treatment.

Exclusionary guidelines:

Half-day PHP is intended as a short-term intervention and not as a substitute for long-term structure and a social support system.

Continuing Stay Criteria - Requires ALL:

1. Patient must have a DSM IV-TR Axis I diagnosis other than a V-code (except as specified in plan designs).
2. Clinical assessment indicates that patient continues to be at some risk to self or others and cannot be treated safely in a lower level of care.
3. Clinical data supports need for continued supervision up to 4 hours a day involving an integrated delivery of a necessary array of intensive services, including but not limited to structure, ADL's, nutrition, hydration or medication compliance and monitoring.
4. Clinical evidence suggests that treatment at this level of care is needed to foster development and/or involvement of support system, including use of community support when appropriate.
5. Patient and family/significant others have demonstrated, through active participation and treatment compliance, motivation and ability to attain treatment goals .
6. Program is actively pursuing discharge planning to ensure that continued treatment occurs at the least restrictive level of care possible.
7. Focus of initial treatment plan has been updated to account for clinical changes and identify medical, substance abuse or psychiatric co-morbidity. Treatment plan remains focused on objectively measurable goals and is time limited.

Comment:

Worsening of the clinical symptoms or multiple unscheduled absences (3 or more) should trigger a review by Medical Director.

Discharge Criteria - Requires ONE:

1. Risks have been reduced to such level that continued services, if necessary, can be safely provided in a less restrictive environment. Stabilization of acute symptoms and short-term treatment goals has been achieved. Family/significant others when available can provide adequate support.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because patient is non-compliant with treatment recommendations. Examples may include but are not limited to: active substance abuse, refusing medications or psychiatric consultation when clinically indicated, poor attendance, failure to readily engage in the treatment process and/or refusal to attend treatment offered by community support groups. There is little evidence that intervention thus far has improved compliance. Patient is not at risk for harm to self or others.
3. There is little evidence that current treatment plan is effective and no alternate appropriate treatment plan has been proposed. Further progress is deemed unlikely at this level.

Adult Psychiatric Home Care

Definition:

Psychiatric home care is treatment that is delivered away from a professional office or institution, usually at patient's home. This may be needed in circumstances when patient is homebound and/or unable to ambulate. The service must be provided by a mental health professional. The type of treatment, its intensity and duration varies according to medical necessity.

Comments:

- 1. This type of care is an interim treatment that arises from the situations in which patient is unable to pursue care at the provider's office site, and is generally time-limited.*
- 2. It is a general expectation that patient will continue to attend treatment at the provider's office as soon as the physical or emotional limitations have been removed.*

Admission Criteria - Requires ALL:

1. Patient will have a DSM IV-TR Axis I diagnosis (other than a V-code except as specified by plan designs).
2. Patient will benefit greatly from the home care treatment, that otherwise will not be accessible due to severe psychological or physical obstacles, preventing patient from coming to provider's office.
3. Family/significant others if available can provide adequate support and will be involved in the treatment process.
4. There is evidence of sufficient motivation for successful participation in treatment at this level of care.

Continuing Stay Criteria - Requires ALL:

1. Patient must have a DSM IV-TR Axis I diagnosis (other than a V-code except as specified by plan designs).
2. Patient continues to be unable to travel to provider's office due to debilitating psychological or physical illness and will benefit from treatment at this level of care. Pt will build adequate coping skills to handle triggers and stress.
3. Clinical evidence suggests that treatment at this level of care is needed to foster the development and/or involvement of a support system.

Comment:

Relapse, worsening of the clinical symptoms or refusal to attend to treatment on one or more occasions should trigger a review by Medical Director.

Discharge Criteria - Requires ONE:

1. The patient has either reached a level of functioning permitting the continuation of treatment in a professional office or has reached full remission of psychiatric illness. Family/significant others if available can provide adequate support.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because patient and/or family or significant others are non-compliant with treatment recommendations. Examples may include but are not limited to: active substance abuse, refusing medications or psychiatric consultation when clinically indicated, failure to readily engage in the treatment process. There is little evidence that intervention thus far has improved compliance.
3. There is little evidence that the current treatment plan is effective. There is no alternate appropriate

treatment plan proposed. Further progress is deemed unlikely at this level.

Child and Adolescent Half Day Partial Hospital Treatment

Definition:

Half-day Partial hospitalization is an ambulatory treatment approach that includes coordinated, intensive, comprehensive, and multidisciplinary treatment usually found in a comprehensive inpatient psychiatric hospital program. It is designed for patients with serious and active mental disorders who require treatment that is not provided in a traditional outpatient office or clinic setting. The partial hospital may be a freestanding unit, a component of a community health center, or part of a hospital complex.

Admission Criteria:

Requires ALL:

1. Patient will have a DSM IV Axis I diagnosis (other than a V-code except as specified by plan designs).
2. The patient is experiencing moderate to severe symptoms and/or functional impairment(s).
3. The patient can be safely and effectively managed in a Partial Hospital setting without significant risk of harm to self/others or decompensation.
4. The patient requires the intensity of half-day structured treatment to obtain the most benefit from coordinated services such as individual, group, milieu, or family therapy, education and/or medical supervision.
5. The patient's environment, living situation, and family system are sufficiently stable to allow for treatment in this care setting.
6. For adolescents, there is evidence of sufficient motivation for successful participation in treatment at this level of care.
7. The treatment plan includes the active participation of the parent(s)/legal guardian(s), unless precluded by legal action.
8. If compromised academic performance is part of the clinical picture, the treatment plan includes verification that an individualized educational plan is in place from the patient's school district, OR a referral for an Individual Education Plan (IEP) by the parent(s)/legal guardian(s) to the home school district will be initiated.

Comments:

1. *Half-day partial hospitalization is used for a child/adolescent who has been recently discharged from full-day partial hospitalization or inpatient care and is using half-day PHP for re-entry into their community and school environment.*
2. *The patient may attend half-day PHP either in the morning or afternoon and attend school in the alternate time block.*
3. *The following guidelines are suggested for the child or adolescent's individualized half-day partial hospitalization treatment plan as clinically indicated:*
 1. *Individual psychotherapy daily.*
 2. *Group psychotherapy daily.*
 3. *Family psychotherapy 2X/week.*
 4. *Milieu therapy daily.*
 5. *Substance Use Disorder - 12 step group (when indicated) 2X/week.*
 6. *Medication management (when indicated) daily.*

Continuing Stay Criteria:

Requires ALL:

1. Patient must have a DSM IV Axis I diagnosis other than a V-code (except as specified in plan designs).
2. Clinical assessment indicates that the patient continues to be at some risk to self or others and cannot be treated safely in a lower level of care.
3. Patient requires frequent medical supervision up to 4 hours a day including an integrated delivery of a necessary array of intensive services including but not limited to patient's need for structure, ADL's, nutrition, hydration or medication compliance and medical monitoring.
4. Clinical evidence suggests that treatment at this level of care is needed to address serious dysfunction in the family system and/or develop an extended support system, including use of community support when appropriate.
5. Family conferences should occur at least twice a week. Parent(s) or guardian is actively educated about mental illness and need for compliance with the treatment plan.
6. Patient and parent(s) or guardians have demonstrated, through active participation, cooperation and treatment compliance, their motivation and ability to attain treatment goals .
7. Focus of initial treatment plan has been updated to account for new clinical information that modifies the treatment approach.
8. Program is actively pursuing adequate discharge planning to promote return to previous level of functioning and to ensure that continued treatment occurs at the least restrictive level of care possible.

Comments:

Worsening of the clinical symptoms or multiple unscheduled absences (3 or more) should trigger a review by Medical Director.

Discharge Criteria:

Requires ONE:

1. Risks have been reduced to such level that continued services, if necessary, can be safely provided in a less restrictive environment. Stabilization of acute symptoms and short-term treatment goals has been achieved. Parent(s) or guardian is supportive and can provide adequate home supervision for the current needs. There is an adequate discharge plan in place.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because patient and/or parent(s) or guardians are non-compliant with the treatment recommendations. Examples include but are not limited to active substance abuse, refusing medications, poor attendance, failure to engage in the treatment process, and/or refusal to attend treatment offered by community support groups, when appropriate. There is little evidence that intervention thus far has improved compliance. Patient is not imminently at risk for harm to self or others.
3. The clinical information offers little evidence that current treatment plan is effective. There is no alternate treatment plan proposed. Further progress is deemed unlikely at this level. evidence that current treatment plan is effective. There is no alternate treatment plan proposed. Further progress is deemed unlikely at this level.

Adult Substance Use Disorder Residential Treatment

Definition:

This section applies to the rehabilitation units of residential treatment centers that provide for 24-hour live-in programs. These offer a structured recovery environment that is staffed 24 hours per day. These programs may be of the Medical Model (corresponding to ASAM level III.1, III.3, or III.5 - ASAM PPC - 2R, 2001) or of the Social Model (corresponding to ASAM level III.1 only). Placement in a Social Model Program should occur only after evaluation has been done by a physician (preferably by a Psychiatrist or Addictionologist) to assess for medical stability and for the presence of Co-Morbid Mental Illness. This level of care is provided only to patients who have a DSM IV-TR Axis I diagnosis of Substance Use Disorder and their substance abuse has caused a significant impairment in their level of social and/or occupational functioning. Patients who are in late stages of detoxification and are not at risk for further physiological deterioration are considered sufficiently medically stable for treatment at this level of care.

Comments:

- 1. In general, there are no established indications in the research literature for housing an adult in a facility during their rehabilitative programming, except for conditions noted in the above Acute Inpatient Rehabilitation criteria. Residential programs of fixed length have repeatedly been shown to have no better and often worse outcomes than intensive outpatient programs*
- 2. The following guidelines are suggested for an individualized Substance Use Disorder residential treatment plan as clinically indicated:*
 - a. Individual counseling daily.*
 - b. Group counseling daily.*
 - c. Family psychotherapy 2X/week.*
 - d. Milieu therapy daily.*
 - e. Substance Use Disorder - 12-step group daily.*
 - f. Medication management (when indicated) 1X/wk.*
- 3. If clinical presentation suggests that intensive family intervention is critical, then patient should be referred to the closest geographical facility to their home. This would facilitate and smooth transition to lower levels of care and aftercare.*
- 4. A good faith effort would be defined as complete adherence to the recommended care plan of the facility attended along with routine attendance at self-help meetings.*

Admission Criteria:

Section A. Must satisfy ALL of the following criteria:

1. The patient is at minimal risk of withdrawal and there is little chance that withdrawal from psychoactive substances could potentially be life threatening.
2. There is minimal risk that the patient's medical condition(s) or the presence of medical complications place the patient in imminent danger of serious health risk and they can be managed at a Residential Treatment Level of Care. If there is a medical condition requiring treatment or monitoring, it is expected that physician availability and involvement would be consistent with current best practices of care.
3. The patient may have a comorbid psychiatric condition that is likely to interfere with abstinence, recovery, or stability but is not so severe as to warrant acute inpatient psychiatric hospitalization. If this criterion is satisfied, a psychiatrist must be involved in the treatment.
4. The patient must meet the following criteria:
 - a. The patient is coherent, rational, and oriented for treatment.

- b. The mental state of the patient does not preclude the patient's ability to:
 - i. comprehend and understand the materials presented
 - ii. participate in rehabilitation/treatment process.

Section B. Must satisfy at least ONE of the following criteria:

1. The patient is in need of containment and behavioral shaping due to high-risk behaviors resulting from impaired impulse control that could not be safely done in a less restrictive setting.
2. The patient is at imminent risk of relapse as a result of one of the following:
 - a. intense cravings
 - b. increased severity of substance related depression or anxiety
 - c. severely impaired ability to delay immediate gratification
 - d. acute escalation of relapse behaviors and this behavior could not be managed in a less restrictive level of care
3. The patient's current living situation is such that substance use is highly likely at home due to one of the following:
 - a. non sober or non supportive family members at home
 - b. ongoing physical, sexual or emotional abuse at home
4. Severe social isolation or withdrawal from social contacts and there are psychosocial interventions that are likely to impact either the patient or his/her living condition within a brief period of time.
5. Virtually all of the patient's daily activities revolve around obtaining, using, and/or recuperating from the effects of abusive substances.
6. There is documented evidence that good faith efforts (see comment section #4) at appropriately licensed Partial Hospital or Structured Outpatient Treatment Settings were unsuccessfully attempted.

Section C. Must satisfy ONE of the following criteria:

1. The patient demonstrates evidence of having decided to take the appropriate steps to alter or stop problem behaviors and he/she appears to be committed to a change in lifestyle (corresponding to Prochaska, DiClemente & Norcross, 1994 "Determination" stage of Motivation).
2. The patient is in need of brief, intensive motivational enhancement strategies that are available only in a 24 hour structured setting (i.e. the patient has marked difficulty with or opposition to treatment with imminent dangerous consequences likely if intervention is not successful [corresponding to Prochaska, DiClemente & Norcross, 1994 "Contemplative or Pre-Contemplative Stage of Motivation"]). This is generally offered as a time limited intervention with the hope of engaging the patient in treatment
3. Logistic impairments (e.g., distance from treatment facility, mobility limitations, etc.) preclude participation in a partial hospitalization or outpatient treatment service.

Continuing Stay Criteria - Requires ONE from Section A and ALL from Section B:

Section A: Requires at least ONE

1. The patient has a co-morbid psychiatric condition that remains severe enough as to interfere with abstinence, recovery and/or prevents transition to a less restrictive level of care there is evidence of aggressive management of the psychiatric condition by mental health specialists, preferably a psychiatrist.
2. The patient remains at imminent risk of relapse as a result of intense cravings, increased severity of substance related depression or anxiety, severely impaired ability to delay immediate gratification, or acute escalation of relapse behaviors and this behavior could not be managed in a less restrictive level of care.
3. The patient continues to require the daily active professional staff intervention due to ongoing significant medical and/or psychiatric co-morbid symptoms and/or the need for frequent medication adjustment including use of PRN medication and/or laboratory monitoring.

Section B: Requires ALL

1. Family members or significant others have demonstrated intensive participation from the onset of treatment. There should be at least 1 family conference with the patient present every 3-4 days. (If part of the rationale for hospitalization has to do with poor family support, this criterion may not be reasonable).
2. Clinical evidence suggests that the psychosocial stressors precipitating this admission are being actively addressed. The psychosocial interventions are likely to impact either the patient or his/her living condition within a brief period of time, but the patient's current living situation is such that substance use is highly likely at home. If such interventions are not likely to impact the home situation, then it could be demonstrated that an alternative sober living environment is actively sought within 72-hours.
3. The program is actively pursuing a plan to ensure that the patient participates in a continuing recovery program after discharge. The plan should provide for continued treatment to occur at the least restrictive level of care possible. The treatment team is making diligent efforts to encourage the patient and his family/significant others to initiate treatment in a community support group and to clear the patient's home of all substances of abuse.
4. Focus of the initial treatment plan is being continuously updated to account for clinical changes and identify medical, substance abuse or psychiatric co-morbidity. Treatment plan remains focused on objectively measurable goals and is time limited.
5. There is evidence that the patient is improving and internalizing motivation toward recovery but the patient demonstrates a lack of sufficient tools to remain sober at a less restrictive level of care. The patient has demonstrated through active participation and treatment compliance the ability to attain treatment goals and remain abstinent.

Comment:

Worsening of the clinical symptoms should trigger a review by Medical Director.

Discharge Criteria - Requires ONE:

1. The patient's medical/psychiatric condition has stabilized and risks of imminent relapse have been reduced to a level where services can be safely provided in a less restrictive environment. The post-discharge plan offers the patient enough sober support to promote continued recovery. Family/significant others if available can provide adequate support.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because the patient is non-compliant with treatment and/or has no desire to attend self-help abstinence based groups. Examples of non-compliance include, but are not limited to: active substance abuse, refusal of clinically indicated medications or psychiatric consultation, poor attendance at program activities, failure to engage in the treatment process and refusal to attend community support groups recommended by the program. Family or significant others (when available) fail to participate in the patient's treatment. There is little evidence that intervention thus far has improved compliance.
3. The clinical information does not offer evidence that the current treatment plan is effective. There is no alternate appropriate treatment plan proposed and further progress toward specific measurable treatment goals is deemed unlikely within 5 days at this level.

Comment:

Patients who have co-occurring Mental Disorders must clearly have the Mental Health Disorder stabilized prior to admission to a non Dual Diagnosis capable program.

Adult Substance Use Disorder Half Day Partial Hospital Treatment

Definition:

MHN defines its Half-Day Partial Hospital Programs (HD-PHP) as facilities providing ambulatory care, and having the requisite credentialing to provide up to 20 hours per week but no more than 4 hours a day, of skilled treatment interventions. During the course of treatment, the patients returns home or to a sober living environment (after each session) in order to facilitate a smooth transition to lower levels of care. These consist of diversified treatment modalities to address the problems of substance abuse. MHN requires that each staff person, from CD counselor to addictionologist, be certified or licensed in their particular level of expertise.

Treatment strategies are diversified, and individually fitted to the needs of the patient. HD-PHP may be utilized for substance abuse treatment alone, or as a dual substance abuse/mental health program. The duration of the program is not pre-established but individually determined, according to the needs and current status of the patient. The HD-PHP may be part of a Full Day program where treatment has been adjusted to patient's needs and the structure of the Full Day is no longer required. The program can be part of a medical setting, or a freestanding facility. If the latter, it must have access to a medical center within a reasonable period of time, to treat any emergencies that may arise.

Comments:

1. *In some cases, HD-PHP is used sparingly for substance abusing patients after an unusually severe or complicated detoxification. During the HD-PHP phase, the patient is further stabilized and prepared for continuation of rehabilitation in an intensive outpatient program. In other cases HD-PHP may be used for continuation of detoxification, after the acute life-threatening phase of detoxification is completed.*
2. *HD-PHP is intended to be used either as an interim treatment setting between higher and lower levels of care, or as an initial treatment intervention. This program would allow patients to receive intensive and structured treatment, under medical supervision, while they continue to cope and live in their home environment when conducive to recovery. Substance use disorder HD- PHP is as a short-term intervention and not as a substitute for long-term structure and a social support system.*
3. *HD-PHP is utilized by individuals who are seriously mentally or emotionally impaired but who are able to live in the community and present no imminent potential for harm to themselves or to others. Patients who benefit from a HD-PHP include:*
 1. *Patients in acute crisis who use HD-PHP to prevent hospitalization; and*
 2. *Patients "stepped down" from inpatient care when medically necessary.*
 3. *The following guidelines are suggested for an individualized HD-PHP treatment plan as clinically indicated:*
 1. *Individual psychotherapy daily.*
 2. *Group psychotherapy daily.*
 3. *Family psychotherapy 2X/week.*
 4. *Milieu therapy daily.*
 5. *Substance Use Disorder – self-help group (when indicated) 2X/week.*
 6. *Medication management (when indicated) daily.*

Admission Criteria: Requires ALL

1. There is a clearly documented pattern of substance abuse or dependence that meets the DSM IV TR criteria required for such a diagnosis . Collateral information may be gathered to support the diagnosis when information from the patient is inadequate.
2. The patient is not showing signs or symptoms of serious withdrawal suggesting the need of admission to a

- higher level of care.
3. The patient's behaviors and risk factors demonstrate that s/he requires up to 4 hours a day of containment, structured treatment, care and education.
 4. If comorbid medical and/or psychiatric conditions exist, they must be manageable at the partial hospital level of care and there must be adequate medical coverage present.
 5. The patient's functional capacity is high enough to allow for meaningful treatment participation.
 6. The patient has the impulse control necessary to avoid the use of substances. There is a moderate to high likelihood that the patient is able to sustain an acceptable degree of abstinence between treatment sessions.
 7. The patient's recovery environment, living situation and social support system are sufficiently stable to allow for treatment at this level of care. If environment, and support systems have not been stable, it is expected that the patient will be referred to a supportive living environment, such as a recovery or half way house.
 8. Clinical evidence suggests this is the least restrictive level of care at which the patient can be safely and effectively treated.

Continuing Care Criteria: Requires ALL

1. The patient must have a DSM-IV TR axis I diagnosis and supporting clinical criteria, for a substance use disorder / dual diagnosis disorder.
2. Clinical assessment indicates that the patient remains at moderate to moderately high risk of instability or likely relapse (an ASAM risk level of 2 to 3).
3. The patient requires continued medical monitoring for up to 8 hours a day to manage comorbid medical or psychiatric conditions that predispose the patient to imminent and sustained relapse risk.
4. Patient and their family/significant others have demonstrated motivation and engagement in the treatment process by complying with treatment recommendations and attaining treatment goals. This necessarily includes the use of community-based self-help groups. It also implies that the treatment team is making diligent efforts to encourage the patient and family / significant other, to clear the patient's home of all substances of abuse.
5. The treatment program is actively pursuing adequate discharge planning to ensure continuity of care and that fosters abstinence. Ongoing treatment should always occur at the least restrictive level of care that will safely and effectively address the patient's primary and comorbid disorders.
6. The focus of the initial treatment plan is based on objective behavioral goals that are being continually updated to account for clinical changes and actively identify medical, substance abuse or psychiatric co-morbidities that might delay treatment progress. The treatment plan is also updated to match the patient's current psychosocial problems. Treatment interventions are time-limited and expected to resolve or improve clinical symptoms within a reasonable period.
7. The patient's readiness to change has been demonstrated by continued behavioral effort at the assigned tasks, and compliance with all treatment requirements, including self help groups, , obtaining a temporary sponsor and taking any medication recommended for treatment of comorbid medical or psychiatric conditions. Patients who do not meet these requirements should be considered for motivational enhancement therapy delivered in an outpatient setting to prepare them for effective treatment.
8. As the patient improves in treatment at this level of care, it is expected that the interval between days of treatment shall be gradually increased, and that appropriate planning is initiated for the transitioning of the patient to a lower and less restrictive level of care.

Comment:

- *In most instances, as the patient improves in treatment at this level of care, it is expected that the interval between days of treatment shall be gradually increased, and that appropriate planning is initiated for the transitioning of the patient to a less restrictive level of care.*
- *One relapse, worsening of the clinical symptoms or multiple unscheduled absences (3 or more) should trigger a review by the Medical Director.*

Discharge Guidelines: Requires ONE

1. Treatment goals have been achieved, acute symptoms have been stabilized and relapse risk has been reduced to the extent that continued services, if necessary can be safely provided in a less restrictive environment. The patient is able to maintain reasonable abstinence with the help of a support system. (This may include recovery or sober living environment, family or significant other support if appropriate, and self help or abstinence group fellowship.)
2. The probability of successful outcome with continued treatment at this level of care is seriously compromised because the patient is non-compliant with treatment recommendations. Examples may include, but are not limited to; active substance abuse, refusing medications or psychiatric consultation when clinically indicated, poor attendance, failure to readily engage in the treatment process and / or refusal to attend treatment offered by community support groups when it is thought to be a critical element in successful treatment. There is little evidence that intervention thus far has improved compliance or readiness to change addiction behaviors. Patient is not at risk for harm to self or others.
3. There is little evidence that current treatment plan is effective. There is no alternate appropriate treatment plan proposed. Further progress is deemed unlikely at this level.

Comment:

- *If patient readiness to change is not consistent with the level of care proposed due to numbers 2 and 3 above, the patient may require intervention strategies at an outpatient level of care (office-based) to promote and enhance motivation for compliance with rehabilitation and abstinence treatment strategies.*
- *Efforts by family members and significant others, coming together to approach the patient, under the guidance of a therapist, may be beneficial at the out patient level of care, to prepare the patient for more intense treatment levels.*

Adult Substance Use Disorder Relapse Prevention Outpatient Aftercare Group

Definition:

Relapse Prevention Group is an aftercare group treatment, is typically used as step-down from IOP or PHP. Minimum group leadership requirement includes a certified substance abuse counselor supervised by mental health/substance abuse professional. The sessions are weekly and last up to 90 minutes. The duration of the program varies according to medical necessity.

Comments:

- *Relapse Prevention Aftercare Group is frequently used as a typical step-down treatment modality after IOP for most substance abusers. It has the advantages of longer duration of program contact and support for the patient's work functioning, support of the patient in their actual environment.*
- *A single drug binge episode may be adequately addressed in this treatment setting and would not necessarily be in itself a reasonable cause for stepping up treatment to a higher level of care.*
- *Relapse Prevention Aftercare Group will not replace the need for patient's involvement in local self-help groups and often alumni groups and activities. It can also co-exist with other treatment modalities as medically necessary (medication management, individual counseling, family, couple or marital counseling).*

Admission Criteria - Requires ALL:

1. There is an DSM IV-TR Axis I diagnosis of Substance Use Disorder and there is a documented history of recent substance abuse or dependence that was severe enough to markedly interfere with social and occupational functioning and cause significant impairment in activities of daily living.
2. Patient requires continued participation in the relapse prevention group in order to maintain abstinence and seek additional support in defending against urges and cravings and to build adequate coping skills to handle triggers and stress.
3. Patient's recovery environment, living situation, and social support system are sufficiently stable to allow for meaningful participation in the Relapse Prevention Aftercare Group. There is a strong expectation that patient will attend self-help or abstinence community support groups.
4. There is evidence of sufficient motivation for successful participation in treatment at this level of care; and
5. Patient has demonstrated, or there is reason to believe that the patient can avoid the abuse of substances between treatment sessions.

Continuing Stay Criteria - Requires ALL:

1. Patient must have a DSM IV-TR Axis I diagnosis of substance abuse or chemical dependence.
2. Patient with substance abuse diagnosis continues to be at risk for relapse due to active stress, frequent urges or cravings and/or patient has significant co-existing psychiatric symptoms.
3. Patient requires continued participation in the group in order to maintain abstinence and seek additional support in defending against urges and cravings of substance use and to build adequate coping mechanisms to handle triggers and stress.
4. Patient needs to further develop a support system, including use of self-help, sponsor and access to community resources. There is evidence that patient has attempted to engage the participation of family members or significant others as part of their sober support system.
5. The patient is able to maintain abstinence between group sessions.

Comment:

A single relapse, worsening of the clinical symptoms or multiple unscheduled absences (3 or more) should trigger a review by Medical Director.

Discharge Criteria - Requires ONE:

1. Patient is able to maintain abstinence with help from the support system available. Patient is actively participating (where appropriate) in community sponsored self-help groups, attends them regularly and has a sponsor. Family/significant others if available can provide adequate support.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because patient and/or family or significant others are non-compliant with treatment recommendations. Examples may include but are not limited to: active substance abuse, refusing medications or psychiatric consultation when clinically indicated, poor attendance, failure to readily engage in the treatment process and/or refusal to attend treatment offered by community support groups when it is thought to be a critical element in successful treatment. There is little evidence that intervention thus far has improved compliance.
3. There is little evidence that the current treatment plan is effective. There is no alternate appropriate treatment plan proposed. Further progress is deemed unlikely at this level.

Child and Adolescent Substance Use Disorder Residential Treatment Center Rehabilitation Treatment

Definition:

This section applies to the rehabilitation units of residential treatment centers that provide for 24-hour live-in programs. These offer a structured recovery environment that is staffed 24 hours per day. These programs may be of the Medical Model (corresponding to ASAM level III.1, III.3, or III.5 - ASAM PPC - 2R, 2001) or of the Social Model (corresponding to ASAM level III.1 only). Placement in a Social Model Program should occur only after evaluation has been done by a physician (preferably by a Psychiatrist or Addictionologist) to assess for medical stability and for the presence of Co-Morbid Mental Illness. This level of care is provided only to patients who have a DSM IV-TR Axis I diagnosis of Substance Use Disorder and their substance abuse has caused a significant impairment in their level of social and/or occupational functioning. Patients who are in late stages of detoxification and are not at risk for further physiological deterioration are considered sufficiently medically stable for treatment at this level of care.

Comments:

In general, there are no established indications in the research literature for housing a child or adolescent in a facility during their rehabilitative programming, except for conditions noted in the Acute Residential Rehabilitation criteria listed below. There is no established peer-reviewed literature support to suggest that programs of fixed length have better outcomes than individually tailored programs and individually programs are encouraged by ASAM. Lengthy confinements of unmotivated and/or antisocial adolescents are not justified by the outcome literature. The following guidelines are suggested for an individualized Substance Use Disorder inpatient rehabilitation treatment plan as clinically indicated:

- 1. Individual counseling daily.*
- 2. Group counseling daily.*
- 3. Family psychotherapy 2-3X/week.*
- 4. Milieu therapy daily.*
- 5. Substance Use Disorder - 12-step group or fellowship group daily.*
- 6. Medication management daily, if indicated.*

Patients who have co-occurring Mental Disorders must clearly have the Mental Health Disorder stabilized prior to admission to a non Dual Diagnosis capable program.

Admission Criteria:

Section A: The treatment plan includes the active participation of the parent(s)/legal guardian(s), unless precluded by legal action.

Section B: Must satisfy ALL five of the following criteria:

1. The patient is at minimal risk of withdrawal and there is little chance that withdrawal from psychoactive substances could potentially be life threatening.
2. There is minimal risk that the patient's medical condition(s) or the presence of medical complications place the patient in imminent danger of serious health risk and they can be managed at a Residential Treatment Level of Care. If there is a medical condition requiring treatment or monitoring, it is expected that physician availability and involvement would be consistent with current best practices of care.
3. The patient may have a comorbid psychiatric condition that is likely to interfere with abstinence, recovery, or stability but is not so severe as to warrant acute inpatient psychiatric hospitalization. If this criterion is satisfied, a psychiatrist must be involved in the treatment.
4. The patient must meet the following criteria in all three of the following clauses:
 - a. The patient is coherent, rational, and oriented for treatment.
 - b. The mental state of the patient does not preclude the patient's ability to:
 - i. comprehend and understand the materials presented
 - ii. participate in rehabilitation/treatment process.
5. The patient must meet the following criteria:
 - a. The adolescent is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post pubescent; not growth retarded).
 - b. The history of the adolescent reflects cognitive development of at least 11 years of age.

Section C: Must satisfy at least ONE of the following criteria:

1. The patient is in need of containment and behavioral shaping due to high-risk behaviors resulting from impaired impulse control that could not be safely done in a less restrictive setting.
2. The patient is at imminent risk of relapse as a result of one of the following:
 - a. intense cravings
 - b. increased severity of substance related depression or anxiety
 - c. severely impaired ability to delay immediate gratification
 - d. acute escalation of relapse behaviors and this behavior could not be managed in a less restrictive level of care
3. The patient's current living situation is such that substance use is highly likely at home due to one of the following:
 - a. non sober or non supportive family members at home
 - b. ongoing physical, sexual or emotional abuse at home
4. Severe social isolation or withdrawal from social contacts and there are psychosocial interventions that are likely to impact either the patient or his /her living condition within a brief period of time.
5. Virtually all of the patient's daily activities revolve around obtaining, using, and/or recuperating from the effects of abusive substances.
6. There is documented evidence that good faith efforts (see comment section #4) at appropriately licensed Partial Hospital or Structured Outpatient Treatment Settings were unsuccessfully attempted.
7. The adolescent patient displays:

- a. a documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, other criminal charges, etc.); and/or **OR**
- b. a recent history of moderate to severe conduct disorder, as defined in the Diagnostic and Statistical Manual, or impulsive disregard for social norms and rights of others; and/or **OR**
- c. a documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent which interferes with the capacity to remain behaviorally stable.

Section D: Must satisfy ONE of the following criteria:

- 1. The patient demonstrates evidence of having decided to take the appropriate steps to alter or stop problem behaviors and he/she appears to be committed to a change in lifestyle (corresponding to Prochaska, DiClemente & Norcross, 1994 "Determination" stage of Motivation).
- 2. The patient is in need of brief, intensive motivational enhancement strategies that are available only in a 24 hour structured setting (i.e. the patient has marked difficulty with or opposition to treatment with imminent dangerous consequences likely if intervention is not successful [corresponding to Prochaska, DiClemente & Norcross, 1994 "Contemplative or Pre-Contemplative Stage of Motivation"]). This is generally offered as a time limited intervention with the hope of engaging the patient in treatment.
- 3. Logistic impairments (e.g., distance from treatment facility, mobility limitations, etc.) preclude participation in a partial hospitalization or outpatient treatment service.

Continuing Stay Criteria - Requires ONE from Section A and ALL from Section B:

Section A: Requires at least ONE

- 1. The patient has a co-morbid psychiatric condition that remains severe enough as to interfere with abstinence, recovery and/or prevents transition to a less restrictive level of care there is evidence of aggressive management of the psychiatric condition by mental health specialists, preferably a psychiatrist.
- 2. The patient remains at imminent risk of relapse as a result of intense cravings, increased severity of substance related depression or anxiety, severely impaired ability to delay immediate gratification, or acute escalation of relapse behaviors and this behavior could not be managed in a less restrictive level of care.
- 3. The patient continues to require the daily active professional staff intervention due to ongoing significant medical and/or psychiatric co-morbid symptoms and/or the need for frequent medication adjustment including use of PRN medication and/or laboratory monitoring.

Section B: Requires ALL

- 1. Parent(s)/legal guardian(s) have demonstrated intensive participation from the onset of treatment. There should be at least 1 family conference with the patient present every 2-3 days (If part of the rationale for hospitalization has to do with poor family support, this criteria may not be necessary).
- 2. Clinical evidence suggests that the psychosocial stressors precipitating this admission are being actively addressed. The psychosocial interventions are likely to impact either the patient or his/her living condition within a brief period of time, but the patient's current living situation is such that substance use is highly likely at home. If such interventions are not likely to impact the home situation, then it could be demonstrated that an alternative sober living environment is actively sought within 72-hours.

3. Facility and parent(s)/legal guardian(s) are actively pursuing adequate discharge planning to promote return to previous level of functioning and to ensure that the patient actively participates in a continuing recovery program after discharge. The plan should provide for continued treatment to occur at the least restrictive level of care possible. The treatment team is making diligent efforts to encourage the patient and his /her parent(s)/guardian(s) to initiate treatment in a community support group and to clear the patient's home of all substances of abuse or to pursue an alternative sober living environment
4. Focus of the initial treatment plan is being continuously updated to account for clinical changes and identify medical, substance abuse or psychiatric co-morbidity. Treatment plan remains focused on objectively measurable goals and is time limited.
5. There is evidence that the patient is improving and internalizing motivation toward recovery but the patient demonstrates a lack of sufficient tools to remain sober at a less restrictive level of care. The patient has demonstrated through active participation and treatment compliance the ability to attain treatment goals and remain abstinent.

Comment:

Worsening of the clinical symptoms should trigger a review by Medical Director.

Discharge Criteria - Requires ONE:

1. The patient's medical/psychiatric condition has stabilized and risks of imminent relapse have been reduced to a level where services can be safely provided in a less restrictive environment. The post-discharge plan offers the patient enough sober support to sustain continued recovery. Parent(s)/legal guardian(s) can offer adequate support and supervision or a suitable placement alternative has been identified. Facility is making diligent efforts to clear household of all substance of abuse. There is an adequate discharge plan in place.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because the patient and/or parent(s)/legal guardian(s) are non-complaint with treatment plan, and/or parent(s)/legal guardian(s) does not give permission and require patient to attend 12-step or other fellowship support program. Examples of non-adherence include, but are not limited to: active substance abuse, refusal of clinically indicated medications or psychiatric consultation, poor attendance at program activities, failure to engage in the treatment process and refusal to attend community support groups recommended by the program, patient and/or parent(s)/legal guardian(s) fail to participate in family therapy. There is little evidence that intervention thus far has improved adherence.
3. The clinical information does not offer evidence that the current treatment plan is effective. There is no alternate appropriate treatment plan proposed and further progress towards specific measurable treatment goals is deemed unlikely at this level.

Child and Adolescent Substance Use Disorder Half-Day Partial Hospital Treatment

Definition:

MHN defines its Partial Hospital Programs as facilities providing ambulatory care, and having the requisite credentialing to provide up to 20 hours per week but no more than 4 hours a day, of skilled treatment interventions. During the course of treatment, the patient returns home (after each session) in order to facilitate a smooth transition to lower levels of care. These consist of diversified treatment modalities to address the problems of substance abuse. MHN requires that each staff person, from CD counselor to addictionologist, be certified or licensed in their particular level of expertise.

Treatment strategies are diversified, and individually fitted to the needs of the patient. Half-day Partial Hospitalization, HD-PHP, may be utilized for substance abuse treatment alone, or as a dual substance abuse/mental health program. The duration of the program is not pre-established but individually determined, according to the needs and current status of the patient. The partial hospital may be part of a medical setting, or free standing facility. If the latter, it must have access to a medical center within a reasonable period of time, to treat any emergencies that may arise.

Comments:

- *In some cases, HD-PHP is used sparingly for substance abusing patients after an unusually severe or complicated detoxification. During the HD-PHP phase, the patient is further stabilized and prepared for continuation of rehabilitation in an intensive outpatient program. In other cases, HD-PHP may be used for continuation of detoxification, after the acute life-threatening phase of detoxification is completed.*
- *HD-PHP is intended to be used either as an interim treatment setting between higher and lower levels of care, or as an initial treatment intervention that would allow patients to receive intensive and structured treatment while they continue to cope and live in their home environment when conducive to recovery. Substance use disorder HD-PHP is as a short-term intervention and not as a substitute for long-term structure and a social support system.*
- *HD-PHP is utilized by individuals who have a serious substance use disorder but who are able to live in the community and present no imminent potential for harm to themselves or to others. Patients who benefit from a HD-PHP include:*
 1. *Patients in acute crisis who use HD-PHP to prevent hospitalization; and*
 2. *Patients "stepped down" from inpatient care when medically necessary.*
 3. *The following guidelines are suggested for an individualized HD-PHP treatment plan as clinically indicated:*
 1. *Individual psychotherapy daily.*
 2. *Group psychotherapy daily.*
 3. *Family psychotherapy 2 – 3X/week.*

4. *Milieu therapy daily.*
5. *Substance Use Disorder – self-help group (when indicated) 2X/week.*
6. *Medication management (when indicated) daily.*

Admission Criteria: Requires ALL

1. There is a clearly documented pattern of substance abuse or dependence that meets the DSM IV TR criteria required for such a diagnosis . Collateral information may be gathered to support the diagnosis when information from the patient is inadequate.
2. The patient is not showing signs or symptoms of serious withdrawal suggesting the need of admission to a higher level of care .
3. The patient’s behaviors and risk factors demonstrate that s/he requires up to 4 hours a day of containment, structured treatment, care and education.
4. If comorbid medical and/or psychiatric conditions exist, they must be manageable at the partial hospital level of care and there must be adequate medical coverage present.
5. The patient’s functional capacity is high enough to allow for meaningful treatment participation.
6. The patient has the impulse control necessary to avoid the use of substances . There is a moderate to high likelihood that the patient is able to sustain an acceptable degree of abstinence between treatment sessions.
7. The patient's recovery environment , living situation and social support system are sufficiently stable to allow for treatment at this level of care . If environment and/or support system are not sufficiently stable, an intensive outpatient family treatment intervention occurs simultaneous to the patient participating in this level of care .
8. The treatment plan includes the active participation of the parent(s)/legal guardian(s), unless precluded by legal action.
9. Clinical evidence suggests this is the least restrictive level of care at which the patient can be safely and effectively treated.

Continuing Care Criteria: Requires ALL

1. The patient must have a DSM-IV TR axis I diagnosis and supporting clinical criteria, for a substance use disorder / dual diagnosis disorder.
2. Clinical assessment indicates that the patient remains at moderate to moderately high risk of instability or likely relapse (an ASAM risk level of 2 to 3).
3. The patient requires continued medical monitoring for up to 8 hours a day to manage comorbid medical or psychiatric conditions that predispose the patient to imminent and sustained relapse risk.
4. Parent(s)/legal guardian(s) have demonstrated intensive participation from the onset of treatment and have demonstrated motivation and engagement in the treatment process by complying with treatment recommendations and attaining treatment goals . This includes the use of community-based self-help groups when appropriate. The treatment team is making diligent efforts to encourage the patient and

parent(s)/guardian(s) to clear the patient's home of all substances of abuse. There should be at least 1 family conference with the patient present every 2-3 weekdays.

5. The treatment program is actively pursuing adequate discharge planning to ensure continuity of care and that fosters abstinence. Ongoing treatment should always occur at the least restrictive level of care that will safely and effectively address the patient's primary and comorbid disorders.
6. The focus of the initial treatment plan is based on objective behavioral goals that are being continually updated to account for clinical changes and actively identify medical, substance abuse or psychiatric co-morbidity that might delay treatment progress. The treatment plan is also updated to match the patient's current psychosocial problems. Treatment interventions are time-limited and expected to resolve or improve clinical symptoms within a reasonable period.
7. The patient's readiness to change has been demonstrated by continued behavioral effort at the assigned tasks, and compliance with all treatment requirements, including self help groups, obtaining a temporary sponsor and taking any medication recommended for treatment of comorbid medical or psychiatric conditions. Patients who do not meet these requirements should be considered for motivational enhancement therapy delivered in an outpatient setting to prepare them for effective treatment.
8. As the patient improves in treatment at this level of care, it is expected that the interval between days of treatment shall be gradually increased, and that appropriate planning is initiated for the transitioning of the patient to a lower and less restrictive level of care.

Comment:

- *One relapse, worsening of the clinical symptoms or multiple unscheduled absences (3 or more) should trigger a review by the Medical Director.*

Discharge Guidelines: Requires ONE

1. The patient's medical/psychiatric condition has stabilized and risks of imminent relapse have been reduced to a level where services can be safely provided in a less restrictive environment. The post-discharge plan offers the patient enough sober support to sustain continued recovery. Parent(s)/legal guardian(s) can offer adequate support and supervision or a suitable placement alternative has been identified. Facility is making diligent efforts to clear household of all substance of abuse. There is an adequate discharge plan in place.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because the patient and/or parent(s)/legal guardian(s) are non-complaint with treatment plan, and/or parent(s)/legal guardian(s) does not give permission and require patient to attend 12-step or other fellowship support program. Examples of non-adherence include, but are not limited to: active substance abuse, refusal of clinically indicated medications or psychiatric consultation, poor attendance at program activities, failure to engage in the treatment process and refusal to attend community support groups recommended by the program, patient and/or parent(s)/legal guardian(s) fail to participate in family therapy. There is little evidence that intervention thus far has improved adherence.
3. The clinical information does not offer evidence that the current treatment plan is effective. There is no alternate appropriate treatment plan proposed and further progress towards specific measurable treatment goals is deemed unlikely at this level.

Child and Adolescent Substance Use Disorder Relapse Prevention Outpatient Aftercare Group

Definition:

Relapse Prevention Group is an aftercare group treatment, is typically used as step-down from IOP or PHP. Minimum group leadership requirement includes a certified substance abuse counselor supervised by mental health/substance abuse professional. The sessions are weekly and last up to 90 minutes. The duration of the program varies according to medical necessity.

Comments:

- *Relapse Prevention Aftercare Group is frequently used as a typical step-down treatment modality after IOP for most substance abusers. It has the advantages of longer duration of program contact and support for the patient's work functioning, support of the patient in their actual environment.*
- *A single drug binge episode may be adequately addressed in this treatment setting and would not necessarily be in itself a reasonable cause for stepping up treatment to a higher level of care.*
- *Relapse Prevention Aftercare Group will not replace the need for patient's involvement in local self-help groups and often alumni groups and activities. It can also co-exist with other treatment modalities as medically necessary (medication management, individual counseling, or family counseling).*

Admission Criteria - Requires ALL:

1. There is an DSM IV-TR Axis I diagnosis of Substance Use Disorder and there is a documented history of recent substance abuse or dependence that was severe enough to markedly interfere with social and occupational functioning and cause significant impairment in activities of daily living.
2. Patient requires continued participation in the relapse prevention group in order to maintain abstinence and seek additional support in defending against urges and cravings and to build adequate coping skills to handle triggers and stress.
3. Patient's recovery environment, living situation, and social support system are sufficiently stable to allow for meaningful participation in the Relapse Prevention Aftercare Group. Parent(s)/legal guardian(s) are sufficiently motivated to support patient's abstinence. There is a strong expectation that patient will attend self-help or abstinence community support groups.
4. There is evidence of sufficient motivation for successful participation in treatment at this level of care; and,
5. Patient has demonstrated, or there is reason to believe that the patient can avoid the abuse of substances between treatment sessions.

Continuing Stay Criteria - Requires ALL:

1. Patient must have a DSM IV-TR Axis I diagnosis of substance abuse or chemical dependence.
2. Patient with substance abuse diagnosis continues to be at risk for relapse due to active stress, frequent

urges or cravings and/or patient has significant co-existing psychiatric symptoms .

3. Patient requires continued participation in the group in order to maintain abstinence and seek additional support in defending against urges and cravings of substance use and to build adequate coping mechanisms to handle triggers and stress.
4. Patient needs to further develop a support system, including use of self-help, sponsor and access to community resources when appropriate. There is evidence that patient has the support and participation of parent(s)/legal guardian(s) as part of their sober support system.
5. The patient is able to maintain abstinence between group sessions.

Comment:

A single relapse, worsening of the clinical symptoms or multiple unscheduled absences (3 or more) should trigger a review by Medical Director.

Discharge Criteria: Requires ONE:

1. Patient is able to maintain abstinence with help from the support system available. Patient is actively participating (where appropriate) in community sponsored self-help groups, attends them regularly and has a sponsor. Parent(s)/legal guardian(s) provide adequate support.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because the patient and/or parent(s)/legal guardian(s) are non-compliant with treatment recommendations. Examples may include but are not limited to: active substance abuse, refusing medications or psychiatric consultation when clinically indicated, poor attendance, failure to readily engage in the treatment process and/or refusal to attend treatment offered by community support groups recommended by the program, patient and/or parent(s)/legal guardian(s) fail to participate in patient's treatment. There is little evidence that intervention thus far has improved compliance.
3. There is little evidence that the current treatment plan is effective. There is no alternate appropriate treatment plan proposed. Further progress is deemed unlikely at this level.

Texas State Substance Abuse Criteria - General Information

The following Texas State Specific Criteria are found in:

TEXAS ADMINISTRATIVE CODE ... TITLE 28. -- INSURANCE ... Part I -- Texas Department of Insurance ... Chapter 3 -- LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES ... Subchapter HH. -- Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers

28 TAC s 3.8001

Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

1. Abusable glue or aerosol paint -- Glue or aerosol paint that is:
 - A. packaged in a container holding a pint or less by volume or less than two pounds by weight; and
 - B. labeled in accordance with the labeling requirements concerning precautions against inhalation established under the Federal Hazardous Substances Act (15 United States Code 1261, et seq.), and under regulations adopted under that Act.
2. Adolescent -- A person who is 17 years of age or younger.
3. Advanced clinical practitioner -- An individual certified as an advanced clinical practitioner by the Texas Department of Human Services.
4. Aerosol paint -- An aerosol paint product, including a clear or pigmented lacquer or finish.
5. Certified social worker -- An individual who is certified as a certified social worker by the Texas Department of Human Services.
6. Chemical dependency -- The abuse of, or the psychological or physical dependence on, or the addiction to, alcohol or a controlled substance.
7. Chemical dependency counselor -- A person who is licensed by the Texas Commission on Alcohol and Drug Abuse.
8. Chemical dependency treatment center -- A facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician or qualified credentialed counselor and which facility also meets one of the qualifications in subparagraphs (A) -- (D) of this paragraph:
 - A. affiliated with a hospital under a contractual agreement with an established system for patient referral;
 - B. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
 - C. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
 - D. licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.
9. Controlled substance -- A toxic inhalant, or a substance designated as a controlled substance in the Texas Controlled Substances Act (the Health and Safety Code, s 481.002(5)).
10. Facility -- An individual program, entity, organization, or other provider of chemical dependency treatment services.
11. Glue -- An adhesive substance intended to be used to join two surfaces.
12. Intensive outpatient services -- An organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.
13. Licensed professional counselor -- An individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors.

14. Licensed vocational nurse -- A nurse licensed by the Texas State Board of Vocational Nurse Examiners.
15. Partial hospitalization -- The provision of treatment for chemical dependency for persons who require care or support or both in a hospital or chemical dependency treatment center but who do not require 24-hour supervision at least 20 hours per week up to 8 weeks.
16. Payor -- An insurer writing health insurance policies; any preferred provider organization, health maintenance organization, self-insurance plan; or any other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to persons treated by a health care provider in this state pursuant to any policy, plan or contract.
17. Physician -- A licensed doctor of medicine or a doctor of osteopathy.
18. Program -- A particular type or level of service that is organizationally distinct within a facility.
19. Psychiatrist -- An individual who is licensed in the State of Texas to practice psychiatry, who is eligible for, or has received, board certification, and who has hospital affiliation and experience in appropriate use of psychotropic drugs.
20. Psychologist -- An individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists.
21. Qualified credentialed counselor -- An individual who:
 - A. meets the definition established by the Texas Commission on Alcohol and Drug Abuse; or
 - B. is employed outside the State of Texas and licensed, certified, or registered in a profession corresponding to those described in the definition of Qualified Credentialed Counselor established by the Texas Commission on Alcohol and Drug Abuse.
22. Toxic inhalant -- A volatile chemical under this section or under the Health and Safety Code, s 484.002, or abusable glue or aerosol paint under this section or under the Health and Safety Code, s 485.001.
23. Treatment provider -- Any "chemical dependency treatment center" as defined in this section or in the Insurance Code Article 3.51-9, s 2A, and also any certified or licensed practitioner or facility licensed to provide treatment for chemical dependency.
24. Utilization review -- A system for prospective or concurrent review of the appropriateness of health care services being provided or proposed to be provided in this state.
25. Volatile chemical -- A chemical or an isomer of a chemical listed in subparagraphs (A) -- (X) of this definition, as follows:
 - A. acetone;
 - B. aliphatic hydrocarbons;
 - C. amyl nitrite;
 - D. butyl nitrite;
 - E. carbon tetrachloride;
 - F. chlorinated hydrocarbons;
 - G. chlorofluorocarbons;
 - H. chloroform;
 - I. cyclohexanone;
 - J. diethyl ether;
 - K. ethyl acetate;
 - L. glycol ether inter solvent;
 - M. glycol ether solvent;
 - N. hexane;
 - O. ketone solvent;
 - P. methanol;
 - Q. methyl cellosolve acetate;
 - R. methyl ethyl ketone;
 - S. methyl isobutyl ketone;
 - T. petroleum distillate;
 - U. toluene;
 - V. trichloroethane;
 - W. trichloroethylene; and
 - X. xylol or xylene.

28 TAC s 3.8002

Purpose and general provisions

- a. Purpose. The purpose of this subchapter is to provide:
 1. standards for use by payors and chemical dependency treatment providers for the reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency; and
 2. standards for appropriate utilization review and necessary extension of treatment.
- b. Applicability of this subchapter to control costs. To reasonably control the costs of inpatient and outpatient treatment of chemical dependency, benefits for each individual should be provided for the appropriate level in accordance with the provisions of this subchapter.
- c. Reporting of misuse or abuse of standards. Misuse or abuse of the standards in this subchapter by qualified credentialed counselors shall be reported to the appropriate credentialing entity. Misuse or abuse of these standards by payors shall be reported to the Texas Department of Insurance and the Texas Commission on Alcohol and Drug Abuse. Misuse of these standards by treatment providers shall be reported to the Texas Commission on Alcohol and Drug Abuse and the Texas Department of Insurance.
- d. Confidentiality of medical records. Payors and providers shall preserve the confidentiality of individual medical records to the extent required by law.
- e. Severability. If any provision of the sections in this subchapter or its application to any person or circumstance is held to be invalid, such invalidity shall not affect other provisions or applications of sections which can be given effect without the invalid provisions, and to this end, the provisions of each section are declared to be severable.

28 TAC s 3.8003

Criteria

In all chemical dependency treatment utilization review decisions respecting coverage providing benefits for necessary care and treatment, each payor and treatment provider shall use the standards and corresponding criteria in this subchapter; on and after June 1, 1992, utilization review decisions shall comply with all applicable requirements of the Insurance Code, Article 21.58A. These decisions include admission to treatment, the appropriate level of chemical dependency treatment, continuing treatment, transferring to different levels of treatment, or discharge from treatment. Each payor and treatment provider shall also use this set of standards and corresponding criteria to guide decisions concerning reasonable periods of treatment at particular levels of treatment in a chemical dependency treatment center, as defined in s 3.8001 of this title (relating to Definitions) or in the Insurance Code, Article 3.51-9. These standards and corresponding criteria define the conditions under which benefits shall be provided for the necessary care and treatment of chemical dependency. These standards and corresponding criteria are not intended to, nor are they in any way or manner to be construed to, establish standards of clinical care or appropriate clinical practice. The standards and corresponding criteria set forth in this subchapter include recommended lengths of stay for treatment. These recommended lengths of stay are not intended to, nor are they in any way or manner to be construed to, establish absolute minimum or maximum periods for treatment. Initial and continued eligibility for treatment is to be predicated on the patient meeting the standards and corresponding criteria set forth in this subchapter. Disputes resulting from utilization review decisions respecting necessary care and treatment shall be settled on the basis of the criteria in this subchapter; additionally, on and after June 1, 1992, disputes resulting from utilization review decisions respecting necessary care and treatment shall be settled in accordance with applicable requirements of the Insurance Code, Article 21.58A.

28 TAC s 3.8004

Admission and monitoring

- a. The admitting or attending physician shall review and approve in writing within 24 hours each admission to an inpatient hospital, residential detoxification program, or outpatient detoxification program. Physician review and approval shall include determination of the appropriate diagnosis and application of the standards and corresponding criteria as set out in this subchapter to determine the appropriate level of treatment. A physician assessment shall occur prior to any change in the level of treatment or discharge from treatment.
- b. A qualified credentialed counselor shall authorize and approve in writing each admission to a 24-hour residential chemical dependency treatment center, partial hospitalization program, detoxification program, or outpatient program. Review and approval shall include determination of the appropriateness for admission and application of the standards and corresponding criteria as set out in this subchapter to determine the appropriate level of treatment. An assessment completed by a qualified credentialed counselor shall occur prior to any change in the level of treatment or discharge from treatment.

28 TAC s 3.8005

Utilization review

- a. Treatment providers and payors shall provide for utilization review in accordance with the provisions of this subchapter and of Chapter 19, Subchapter R of this title (relating to Utilization Review Agents). Both payor and treatment provider shall make available a qualified credentialed counselor to discuss the appropriateness of treatment, including levels of care, should this become necessary.
- b. Since utilization review as proposed in these standards must be accomplished in a timely manner, information provided telephonically must be supported by documentation in the patient record and available on request for review.
- c. A payor shall not require an individual to have failed an episode of outpatient therapy as a qualification for admission to inpatient therapy if the individual otherwise meets the criteria for admission to inpatient therapy.

Texas Inpatient Detoxification Treatment

28 TAC s 3.8007

Admission criteria for inpatient (hospital or 24-hour residential) detoxification services

- A. Category 1: chemical substance withdrawal. The individual must meet the conditions in one of the clauses (i) -- (vi) of this subparagraph, as follows:
- i. impaired neurological functions as evidenced by:
 - I. extreme depression (e.g., suicidal); and/or
 - II. altered mental state with or without delirium as manifested by:
 - a. disorientation to self;
 - b. alcoholic hallucinosis;
 - c. toxic psychosis;
 - d. altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma; and/or
 - III. history of recent seizures or past history of seizures on withdrawal; and/or
 - IV. presence of any presumed new asymmetric and/or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination);
 - ii. unstable vital signs combined with a history of past acute withdrawal syndromes, that are interpreted by a physician to be indication of acute alcohol/drug withdrawal;
 - iii. evidence of coexisting serious injury or systemic illness, newly discovered or progressive;
 - iv. clinical condition (e.g., agitation, intoxication, or confusion) which prevents satisfactory assessment of items cited in clauses (i) -- (iii) of this subparagraph, indicating placement in an inpatient service may be justified;
 - v. neuropsychiatric changes of a severity and nature that place the patient at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication, etc.);
 - vi. serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains arrhythmia, or hypotension.
- B. Category 2: medical complications. The individual must present a documented condition or disorder which, in combination with alcohol and/or drug use, presents a physician-determined health risk (e.g., GI bleeding; gastritis; anemia, severe; diabetes mellitus, uncontrolled; hepatitis; malnutrition; cardiac disease, hypertension, etc.).
- C. Category 3: major psychiatric illness. The individual must meet the conditions of at least one clause out of clauses (i) -- (v) of this subparagraph, as follows:
- i. a documented DSM III-R AXIS I condition or disorder which, in combination with alcohol and/or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the individual;
 - ii. severe neurological and psychological symptoms : (e.g., anguish; mood fluctuations; overreactions to stress, lowered stress tolerance; impaired ability to concentrate; limited attention span; high level of distractibility; extreme negative emotions; extreme anxiety);
 - iii. danger to others and/or homicidal;
 - iv. uncontrolled behavior endangering self or others, or documented neuropsychiatric changes of a severity and nature that place the individual at imminent risk of harming self or others; An individual is considered eligible for inpatient (hospital or 24-hour residential) admission for detoxification services when the individual either meets the conditions of paragraphs (1) and (2) of this section or fails two previous treatment episodes of outpatient detoxifications.
 1. Diagnosis . The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in either the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners.
 2. Other factors for admission to inpatient (hospital or 24-hour residential) treatment for detoxification. Once the diagnostic criteria for chemical dependency have been met, the conditions of at least one

subparagraph out of subparagraphs (A) -- (C) of this paragraph must also be met. Determination of whether treatment should be provided for an individual patient in a hospital or in an other-treatment-center-based program shall depend on the category or categories of dysfunction explained in subparagraphs (A) -- (C) of this paragraph.

- v. mental confusion and/or fluctuating orientation

28 TAC s 3.8008

Continued stay criteria for inpatient (hospital or 24-hour residential) detoxification services

- a. Eligibility for continued stay for inpatient (hospital or 24-hour residential) detoxification services shall be based on the patient meeting at least one of the criteria in paragraphs (1)- (3) of this subsection.
 - 1. Chemical substance withdrawal complication. The patient must meet the criteria in one of the subparagraphs (A)- (C) of this paragraph, as follows:
 - A. incomplete medically stable withdrawal from alcohol/drugs, as evidenced by documentation of:
 - i. unstable vital signs;
 - ii. continued disorientation;
 - iii. abnormal laboratory findings related to chemical dependency;
 - B. continued cognitive deficit related to withdrawal with the deficit affecting the patient's ability to recognize alcohol/drug use as a problem; or
 - C. laboratory finding which, in the judgment of a physician, indicate that a drug has not sufficiently cleared the patient's system.
 - 2. Major medical complications. Documentation must indicate that a medical condition or disorder (e.g., diabetes mellitus, uncontrolled) continues to present a health risk and is actively being treated.
 - 3. Major psychiatric complication. The patient must meet the criteria in subparagraph (A) or (B) of this paragraph, as follows:
 - A. documentation that a DSM III-R AXIS I psychiatric condition or disorder, which, in combination with alcohol/drug use, continues to present a major health risk, is actively being treated; or
 - B. documentation that severe neurological and/or psychological symptoms have not been satisfactorily reduced but are actively being treated.
- b. The criteria in subsection (a)(1)- (3) of this section shall be considered in determining utilization review points referred to in s 3.8010 of this title (relating to Recommended Length of Stay for Inpatient -- Hospital or 24-Hour Residential -- Detoxification Services).

28 TAC s 3.8009

Discharge criteria for inpatient (hospital or 24-hour residential) detoxification services

The patient is no longer considered eligible for inpatient (hospital or 24-hour residential) detoxification services when the patient fails to meet the criteria for continued stay care for inpatient (hospital or 24-hour residential) detoxification, as addressed in s 3.8008 of this title (relating to Continued Stay Criteria for Inpatient -- Hospital or 24-Hour Residential -- Detoxification Services).

28 TAC s 3.8010

Recommended length of stay for inpatient (hospital or 24-hour residential) detoxification services

The recommended stay period for inpatient (hospital or 24-hour residential) detoxification services is up to 14 days, based on the inpatient detoxification admission criteria in s 3.8007 of this title (relating to Admission Criteria for Inpatient -- Hospital or 24-Hour Residential -- Detoxification Services), with utilization review points, based on continued stay criteria in s 3.8008 of this title (relating to Continued Stay Criteria for Inpatient -- Hospital or 24-Hour Residential -- Detoxification Services), and recommended treatment periods depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission

Texas Inpatient Rehabilitation Treatment

28 TAC s 3.8011

Admission criteria for inpatient rehabilitation/treatment (hospital or 24-hour residential) services

An individual is considered eligible for admission to a residential rehabilitation/treatment service when the individual meets the required conditions of paragraphs (1) and (2) of this section.

1. **Diagnosis.** The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
2. **Other factors for admission to residential rehabilitation/treatment services.** Once the diagnostic criteria for chemical dependency have been met, the patient must meet the conditions of each of the subparagraphs (A)- (D) of the paragraph, in order to be eligible for treatment provided in an adult residential rehabilitation/treatment service program. Once the diagnostic criteria for chemical dependency have been met, the patient must meet the conditions of each of the subparagraphs (A)- (F) of this paragraph in order to be eligible for treatment provided in an adolescent residential rehabilitation/treatment service program.
 - A. **Category 1: medical functioning.** The patient must meet the criteria in clauses (i) and (ii) of this subparagraph.
 - i. A documented medical assessment following admission (except in instances in which the patient is being referred from an inpatient service) indicates that the patient is medically stable and not in acute withdrawal.
 - ii. The patient is not bed-confined or has no medical complications that would hamper participation in the residential service.
 - B. **Category 2: family, social, or academic dysfunction and logistic impairments.** The patient must meet the criteria in at least one clause out of clauses (i)- (v) in this subparagraph.
 - i. The patient manifests severe social isolation or withdrawal from social contacts.
 - ii. The patient lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict which undermines patient's efforts to change).
 - iii. Patient's family and/or significant others are opposed to the patient's treatment efforts and are not willing to participate in the treatment process.
 - iv. Family members and/or significant other(s) living with the patient manifest current chemical dependence disorders, and are likely to undermine treatment.
 - v. Logistic impairments (e.g., distance from treatment facility, mobility limitations, etc.) preclude participation in a partial hospitalization or outpatient treatment service.
 - C. **Category 3: emotional/behavioral status.** The patient must meet the criteria in all three of the clauses (i)- (iii) of this subparagraph.
 - i. Patient is coherent, rational, and oriented for treatment.
 - ii. Mental state of the patient does not preclude the patient's ability to:
 - I. comprehend and understand the materials presented; and
 - II. participate in rehabilitation/treatment process.
 - iii. There is documentation that:
 - I. with continued treatment the patient will be able to improve and/or internalize the patient's motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol and/or drug related issues, etc.);
 - II. interventions, treatment goals, and/or contracts are in place to help the patient deal with or confront the blocks to treatment (e.g., family intervention, employee counseling confrontation, etc.).

- D. Category 4: recent chemical substance use. The patient must meet the criteria in at least one clause out of clauses (i) and (ii) of this subparagraph.
 - i. The patient's chemical substance use is excessive, and the patient has attempted to reduce or control it, but has been unable to do so (as long as chemical substances are available).
 - ii. Virtually all of the patient's daily activities revolve around obtaining, using, and/or recuperating from the effects of chemical substances and the patient requires a secured environment to control the patient's access to chemical substances.
- E. Category 5: maturation level. The patient must meet the criteria in both clauses (i) and (ii) of this subparagraph.
 - i. The adolescent is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post pubescent; not growth retarded).
 - ii. The history of the adolescent reflects cognitive development of at least 11 years of age.
- F. Category 6: developmental status. The adolescent patient must display:
 - i. documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, other criminal charges, etc.); and/or
 - ii. a recent history of moderate to severe conduct disorder, as defined in the Diagnostic and Statistical Manual, or impulsive disregard for social norms and rights of others; and/or
 - iii. documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent which interferes with the capacity to remain behaviorally stable.

28 TAC s 3.8012

Continued stay criteria for inpatient rehabilitation/treatment (hospital or 24-hour residential) services

- a. Eligibility for continued stay in an inpatient rehabilitation/treatment (hospital or 24-hour residential) program shall be based on the patient's meeting at least one of the conditions in paragraph (1) or (2) of this subsection.
 - 1. Chemical dependency rehabilitation/treatment complication. The patient must meet the conditions in subparagraph (A) or (B) of this paragraph.
 - A. Patient recognizes or identifies with the severity of the alcohol and/or drug problem, but demonstrates minimal insight into the patient's defeating use of alcohol/drugs, but documentation in the record indicates that the patient is progressing in treatment.
 - B. Patient:
 - i. identifies with the severity of the patient's alcohol and/or drug problem and manifests insight into the patient's personal relationship with mood-altering chemicals, yet does not demonstrate behaviors indicating that the patient is developing problem solving skills necessary to cope with the problem; and
 - ii. would predictably relapse if moved to a lesser level of care.
 - 2. Psychiatric or medical complications. The patient must meet the conditions in subparagraph (A) or (B) of this paragraph.
 - A. Documentation in the record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the patient is again progressing in treatment.
 - B. Documentation in the record indicates that the patient is being held pending an immediate transfer to a psychiatric, acute medical service or inpatient detoxification alcohol/drug service.
- b. In determining the utilization review points discussed in s 3.8014 of this title (relating to Recommended Length of Stay for Inpatient Rehabilitation/Treatment -- Hospital or 24-Hour Residential -- Services), the criteria in subsection (a)(1) and (2) of this section shall be considered.

28 TAC s 3.8013

Discharge criteria for inpatient rehabilitation/treatment (hospital or 24-hour residential) services

The patient is no longer considered eligible for inpatient rehabilitation/treatment (hospital or 24-hour residential) services for any particular episode when the patient meets the conditions of any one paragraph out of paragraphs (1)- (4) of this section.

1. **Diagnosis**. The patient no longer meets the diagnostic criteria as addressed in s 3.8011(1) of this title (relating to Admission Criteria for Inpatient Rehabilitation/Treatment -- Hospital or 24-Hour Residential -- Services).
2. **Psychiatric illness or medical complication**. The patient must meet the conditions of subparagraph (A) or (B) of this paragraph, as follows:
 - A. documentation that a psychiatric or medical condition should be treated in another setting; or
 - B. documentation that a psychiatric or medical condition which is interfering with alcohol/drug recovery is not being treated.
3. **Chemical dependency rehabilitation/treatment**. The patient must meet all conditions under at least one subparagraph out of subparagraphs (A)- (C) of this paragraph.
 - A. Patient displays behaviors which demonstrate that the patient:
 - i. is medically stable;
 - ii. recognizes or identifies with the severity of chemical substance use;
 - iii. has insight into the patient's defeating relationship with alcohol/drugs;
 - iv. is applying the essential coping skills necessary to maintain sobriety either in a self-help fellowship and/or with post-treatment supportive care.
 - B. The provider and patient have developed an individualized aftercare plan to help the patient maintain the gains made during active treatment.
 - C. In the case of adolescents, the family or adult significant other refuses to participate in treatment (if the discharge plan is to return to the original setting), unless the attending provider can document that the adolescent is making progress toward established treatment goals and can demonstrate that active efforts are being made to involve the family or adult significant other in treatment.
4. **Behavioral factors**. The patient must meet the conditions under subparagraphs (A) and (B) of this paragraph.
 - A. Patient is consistently uncooperative, to the degree that no further progress is likely to occur.
 - B. Greater intensity of service or transfer to another treatment provider would not have a positive impact on the problem.

28 TAC s 3.8014

Recommended length of stay for inpatient rehabilitation/treatment (hospital or 24-hour residential) services

For adult admissions, the recommended length of stay is between 14 and 35 days, with utilization review points and treatment periods, depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission. For adolescent admissions, the recommended length of stay is between 14 and 60 days, with utilization review points and treatment periods, depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission. The utilization review points referred to in this section shall be based on criteria addressed in s 3.8012 of this title (relating to Continued Stay Criteria for Inpatient Rehabilitation/Treatment -- Hospital or 24-Hour Residential -- Services).

Texas Partial Hospital Treatment

28 TAC s 3.8015

Admission criteria for partial hospitalization services

An individual is considered eligible for partial hospitalization admission when the individual meets the conditions of paragraphs (1) and (2) of this section.

1. The criteria for the definition of chemical dependence diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
2. Other factors for admission to adult and/or adolescent partial hospitalization service. The individual has met the diagnostic criteria for chemical dependency in paragraph (1) of this section and must meet the conditions of all four subparagraphs (A)-(D) of this paragraph.
 - A. Category 1: medical functioning. All the conditions in clauses (i)- (iii) of this subparagraph must be met, as follows:
 - i. a documented medical assessment (except in instances in which the patient is being referred from an inpatient service) which indicates that the patient is medically stable and not in acute withdrawal; and
 - ii. the absence of any medical or physical complications that would hamper the patient's participation in the partial hospitalization program; and
 - iii. logistic impairments (e.g., distance from treatment facility, mobility limitations, etc.) that would preclude participation in an outpatient treatment service.
 - B. Category 2: family, social, academic dysfunction. The individual must meet the conditions in at least one clause out of clauses (i) and (ii) of this subparagraph.
 - i. Patient's social system and significant others are supportive of recovery to the extent that the patient can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the patient's addiction.
 - ii. (ii) Patient's family and/or significant others are willing to participate in the Partial Hospitalization Program.
 - C. Category 3: emotional/behavioral status. The individual must meet the conditions of all three clauses of classes (i)- (iii) of this subparagraph.
 - i. Patient is coherent, rational, and oriented for treatment.
 - ii. Mental state of the patient does not preclude the patient's ability to:
 - I. comprehend and understand the materials presented; and
 - II. participate in rehabilitation/treatment process.
 - iii. There is documentation that:
 - I. with continued treatment the patient will be able to improve and/or internalize the patient's motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing and working on alcohol and/or drug related issues, etc.); and
 - II. interventions, treatment goals, and/or contracts are in place to help the patient deal with or confront the blocks to treatment (e.g., family intervention, employee counseling confrontation, etc.).
 - D. Category 4: recent alcohol/drug chemical substance use. The individual must meet the conditions in at least one clause out of clauses (i) and (ii) of this subparagraph.
 - i. The patient's chemical substance use is excessive, and the patient has attempted to reduce or control it, but has been unable to do so (as long as chemical substances are available).
 - ii. Virtually all of the patient's daily activities revolve around obtaining, using, and/or recuperating from the effects of chemical substances

28 TAC s 3.8016

Continued stay criteria for partial hospitalization services

- a. Eligibility for continued stay in a residential rehabilitation/treatment program shall be based on the patient's meeting at least one of the conditions in paragraph (1) or (2) of this subsection.
 1. Chemical dependency rehabilitation/treatment complication. The patient must meet the conditions in subparagraph (A) or (B) of this paragraph.
 - A. Patient recognizes or identifies with the severity of the alcohol and/or drug problem, but demonstrates minimum insight into the patient's defeating use of alcohol/drugs, but documentation in the record indicates that the patient is progressing in treatment.
 - B. Patient identifies with the severity of the patient's alcohol and/or drug problem and manifests insight into the patient's personal relationship with mood-altering chemicals, yet does not demonstrate behaviors that indicate that the patient is developing problem solving skills necessary to cope with the problem.
 2. Psychiatric or medical complications. The patient must meet the conditions in subparagraph (A) or (B) of this paragraph.
 - A. Documentation in the record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the patient is again progressing in treatment.
 - B. Documentation in the record indicates that the patient is being held pending an immediate transfer to a psychiatric, acute medical service or inpatient detoxification alcohol/drug service.
- b. In determining utilization review points discussed in s 3.8018 of this title (relating to Recommended Length of Stay for Partial Hospitalization Services), the criteria in subsection (a)(1) and (2) of this section shall be considered.

28 TAC s 3.8017

Discharge criteria for partial hospitalization services

The patient is no longer considered eligible for partial hospitalization services for any particular episode when the patient meets the conditions under any one paragraph out of paragraphs (1)- (4) of this section.

1. Diagnosis . The patient no longer meets the diagnostic criteria as addressed in s 3.8015(1) of this title (relating to Admission Criteria for Partial Hospitalization Services).
2. Psychiatric illness or medical complication. The patient must meet the conditions under subparagraph (A) or (B) of this paragraph, as follows:
 - A. documentation that a psychiatric or medical condition should be treated in another setting; or
 - B. documentation that a psychiatric or medical condition which is interfering with alcohol/drug recovery is not being treated.
3. Chemical dependency rehabilitation/treatment. The patient must meet all conditions under at least one subparagraph out of subparagraphs (A)- (C) of this paragraph.
 - A. Patient displays behaviors which demonstrate that the patient:
 - i. is medically stable;
 - ii. recognizes or identifies with the severity of chemical substance use;
 - iii. has insight into the patient's defeating relationship with alcohol/drugs;
 - iv. is applying the essential coping skills necessary to maintain sobriety either in a self-help fellowship and/or with post-treatment supportive care.
 - B. The provider and patient had developed an individualized aftercare plan to help the patient maintain the gains made during active treatment.
 - C. In the case of adolescents, the family or adult significant other refuses to participate in treatment, if the discharge plan is to return to the original setting.
4. Behavioral factors. The patient must meet the conditions under subparagraphs (A) and (B) of this paragraph.

- A. Patient is consistently uncooperative, to the degree that no further progress is likely to occur.
- B. Greater intensity of service or transfer to another treatment provider would not have a positive impact on the problem.

28 TAC s 3.8018

Recommended length of stay for partial hospitalization services

For adult admissions, the recommended length of stay for partial hospitalization service is between 14 and 35 days, with utilization review points and treatment periods, depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission. For adolescent admissions, the recommended length of stay is between 14 and 60 days, with utilization review points and treatment periods, depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission. The utilization review points referred to in this section shall be based on criteria addressed in s 3.8016 of this title (relating to Continued Stay Criteria for Partial Hospitalization Services).

Texas Intensive Outpatient Treatment

28 TAC s 3.8019

Admission criteria for intensive outpatient rehabilitation/treatment service

- a. An intensive outpatient rehabilitation/treatment service is defined as one consisting of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.
- b. An individual is considered eligible for treatment in an outpatient service when the individual meets the conditions of paragraph (3) of this subsection, as well as the conditions of paragraph (1) or (2) of this subsection.
 1. The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
 2. Concerning diagnosis of alcohol/drug abuse, the individual must meet the criteria for the definition of chemical substance abuse, as detailed in either the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners.
 3. Concerning factors for admission to an intensive outpatient rehabilitation/treatment service, the patient must have met the diagnostic criteria for chemical dependency under paragraph (1) of this subsection or for abuse under paragraph (2) of this subsection, and must meet the conditions of all four of the subparagraphs (A) -- (D) of this paragraph.
 - A. Category 1: medical functioning. The patient must meet the following criterion: the patient is not bed-confined or has no medical complications that would hamper the patient's participation in the outpatient service.
 - B. Category 2: family, social, academic dysfunction. The patient must meet the criteria of at least one clause out of clauses (i) and (ii) of this subparagraph.
 - i. Patient's social system and significant others are supportive of recovery to the extent that the patient can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the patient's addiction.
 - ii. Patient has no primary or social support system to assist with immediate recovery, but has the social skills to obtain such a support system or to become involved in a self-help fellowship.
 - C. Category 3: emotional/behavioral status. The patient must meet the criteria under all three clauses (i) -- (iii) of this subparagraph.
 - i. Patient is coherent, rational, and oriented for treatment.
 - ii. Mental state of the patient does not preclude the patient's ability to:
 - I. comprehend and understand the materials presented; and
 - II. participate in rehabilitation/treatment process.
 - iii. There is documentation that the patient expresses an interest to work toward rehabilitation/treatment goals.
 - D. Category 4: recent chemical substance use. The patient must meet the following criterion: the patient's chemical substance use is excessive and maladaptive.

28 TAC s 3.8020

Continued stay criteria for intensive outpatient rehabilitation/treatment service

- a. A patient is considered eligible for continued stay in the intensive outpatient rehabilitation/treatment service when the patient meets the diagnostic criteria and the conditions under at least one paragraph out of (subsection (b)(1) and (2) of this section.

- b. Factors for continued intensive outpatient rehabilitation/ treatment services are listed in paragraphs (1) and (2) of this subsection.
 - 1. Alcohol/drug rehabilitation/treatment complication. The patient must meet the conditions of subparagraph (A) or (B) of this paragraph.
 - A. Patient demonstrates an insight and understanding into the patient's personal relationship with mood-altering chemicals, yet is not effectively addressing the life functions of work, social, or primary relationships without the use of mood altering chemicals .
 - B. Patient, while physically abstinent from chemical substance use, remains mentally preoccupied with such use to the extent that the patient is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the patient will effectively address these issues .
 - 2. Psychiatric or medical complications. Documentation in the record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the patient is again progressing in treatment.

28 TAC s 3.8021

Discharge criteria for intensive outpatient rehabilitation/treatment service

The patient is considered eligible for discharge from the outpatient service when the patient meets the conditions for discharge as stated in any one paragraph out of paragraphs (1)- (3) of this section.

- 1. Psychiatric illness or medical complication. The patient must meet the conditions in subparagraph (A) or (B) of this paragraph, as follows:
 - A. documentation that a psychiatric or medical condition should be treated in another setting; or
 - B. documentation that a psychiatric or medical condition which is interfering with alcohol/drug recovery is not being treated.
- 2. Alcohol/drug rehabilitation/treatment. The patient must meet all the conditions in subparagraph (A) or (B) of this paragraph.
 - A. Patient displays behaviors which demonstrate that the patient:
 - i. recognizes or identifies with the severity of chemical substance use;
 - ii. has insight into the patient's defeating relationship with alcohol/drugs; and
 - iii. is applying the essential coping skills necessary to cope with the alcohol and/or drug problem and to maintain abstinence.
 - B. Patient is functioning adequately in assessed deficiencies in the life tasks areas of work, social functioning, or primary relationships.
- 3. Behavioral factors. The patient must meet all the conditions in subparagraphs (A) and (B) of this paragraph.
 - A. Patient is consistently uncooperative, to the degree that no further progress is likely to occur.
 - B. Greater intensity of service or transfer to another treatment provider would not have a positive impact on the problem.

28 TAC s 3.8022

Recommended length of stay for intensive outpatient rehabilitation treatment service

The recommended stay period for intensive outpatient rehabilitation/treatment services is from four to 12 weeks, meeting at least 10 hours per week, based on the criteria in s 3.8019 of this title (relating to Admission Criteria for Intensive Outpatient Rehabilitation/Treatment Service), with utilization review points, based on the criteria in s 3.8020 of this title (relating to Continued Stay Criteria for Intensive Outpatient Rehabilitation/Treatment Service), and recommended treatment periods depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission.

Texas Outpatient Treatment

28 TAC s 3.8023

Admission criteria for outpatient treatment service

- a. An outpatient treatment service is defined as one consisting of at least one to two hours per week.
- b. An individual is considered eligible for treatment in an outpatient treatment service when the individual meets the conditions of paragraph (1) through (3) of this subsection.
 1. The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the International Classification of Diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
 2. Concerning the diagnosis of alcohol/drug abuse, the individual must meet the criteria for the definition of chemical substance abuse, as detailed in either the most current revision of the International Classification of Diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners.
 3. Concerning the factors for admission to an outpatient treatment service, the patient must have met the diagnostic criteria for chemical dependency under paragraph (1) of this subsection or for abuse under paragraph (2) of this subsection, and must meet the conditions of all three subparagraphs (A) -- (C) of this paragraph.
 - A. Category 1: medical functioning. The patient has no medical complications that would hamper the patient's participation in the outpatient treatment services.
 - B. Category 2: family, social, academic dysfunction. The patient must meet the criteria of at least one clause out of clauses (i) or (ii) of this subparagraph. The patient's living environment should be considered as a factor. An individual living in an environment where licit or illicit mood altering substances are being used may not be a candidate for this level of care early in episode of care (early considered the first 30 days).
 - i. The patient's social system and significant others are supportive of recovery to the extent that the patient can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the patient's addiction.
 - ii. The patient has no primary or social support system to assist with immediate recovery, but has the social skills to obtain such a support system or to become involved in a self-help fellowship.
 - C. Category 3: emotional/behavioral status. The patient must meet the criteria under all three clauses (i) -- (iii) of this subparagraph.
 - i. Patient is coherent, rational and oriented for treatment.
 - ii. Mental state of the patient does not preclude the patient's ability to:
 - I. comprehend and understand the materials presented; and
 - II. participate in rehabilitation/treatment process
 - iii. There is documentation that the patient expresses an interest to work toward rehabilitation/treatment goals.

28 TAC s 3.8024

Continued stay criteria for outpatient treatment services

- a. A patient is considered eligible for continued stay in the outpatient treatment service when the patient meets the diagnostic criteria and the conditions under at least one paragraph out of paragraphs (1) or (2) in subsection (b) of this section.
- b. Factors for continued outpatient treatment services are listed in paragraph (1) and (2) of this subsection.

1. Alcohol/drug rehabilitation/treatment complications. The patient must meet the conditions of subparagraphs (A) or (B) of this paragraph.
 - A. Patient demonstrates an insight and understanding into the patient's personal relationship with mood-altering chemicals, yet is not effectively addressing the life functions of work, social or primary relationships without the use of mood altering chemicals .
 - B. Patient, while physically abstinent from chemical substance use, remains mentally preoccupied with such use to the extent that the patient is unable to adequately address primary relationship, social or work tasks, but there are indications that with continued treatment, the patient will effectively address these issues.
2. Psychiatric or medical complications. Documentation in the record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the patient is again progressing in treatment.

28 TAC s 3.8025

Discharge criteria for outpatient treatment service

The patient is considered eligible for discharge from the outpatient treatment service when he or she meets the conditions for discharge as stated in any one of paragraphs (1) -- (4) of this section.

1. A documented assessment which supports that the patient does not meet the diagnostic criteria for alcohol/drug dependence or abuse.
2. Psychiatric illness or medical complication. The patient must meet the conditions in subparagraphs (A) or (B) of this paragraph, as follows:
 - A. documentation that a psychiatric or medical condition should be treated in another setting; or
 - B. documentation that a psychiatric or medical condition which is interfering with alcohol/drug recovery is not being treated.
3. Alcohol/drug rehabilitation/treatment. The patient must meet all the conditions in subparagraphs (A) or (B) of this paragraph.
 - A. Patient displays behaviors which demonstrate that the patient:
 - i. recognizes or identifies with the severity of chemical substance use;
 - ii. has insight into the patient's defeating relationship with alcohol/drugs: and
 - iii. is applying the essential coping skills necessary to cope with the alcohol and/or drug problem and to maintain abstinence.
 - B. Patient is functioning adequately in assessed deficiencies in the life task areas of work, social functioning, or primary relationships.
4. Behavioral factors. The patient must meet all the conditions in subparagraphs (A) and (B) of this paragraph.
 - A. Patient is consistently uncooperative, to the degree that no further progress is likely to occur.
 - B. Greater intensity of service or transfer to another treatment provider would not have a positive impact on the problem.

28 TAC s 3.8026

Recommended length of stay for outpatient treatment service

The recommended stay period for outpatient treatment services is up to 6 months, meeting at least one hour every two weeks based on the criteria in s 3.8023 of this title (relating to Admission Criteria for Outpatient Treatment Service); with utilization review, based on the criteria in s 3.8024 of this title (relating to Continued Stay Criteria for Outpatient Treatment Service), and recommended treatment periods depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission.

Texas Outpatient Detoxification Treatment

28 TAC s 3.8027

Admission criteria for outpatient detoxification treatment service

An individual is considered eligible for treatment in an outpatient detoxification treatment service when the individual meets the conditions of paragraphs (1) and (2) of this subsection.

1. The diagnosis must meet the criteria for the definition of substance (chemical) dependence, as detailed in the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
2. Once the diagnostic criteria for substance (chemical) dependency as described in subsection (1) have been met, the conditions of all subparagraphs (A) -- (D) of this paragraph must also be met.
 - A. Category 1: chemical substance withdrawal. The individual is expected to have a stable withdrawal from alcohol/drugs.
 - B. Category 2: medical functioning. The patient must meet all the criteria in clauses (i) -- (viii) of this subparagraph.
 - i. No history of recent seizures or past history of seizures on withdrawal,
 - ii. Lack clinical evidence of altered mental state as manifested by:
 - I. disorientation to self,
 - II. alcoholic hallucinations,
 - III. toxic psychosis,
 - IV. altered level of consciousness, as manifested by clinical significant obtundation, stupor, or coma.
 - iii. The symptoms are not due to a general medical condition.
 - iv. Absence of any presumed new asymmetric and/or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination).
 - v. The patient must have vital signs interpreted by a physician to be stable, without a previous history of complications from acute chemical substance withdrawal, and judged to be free of a physician-determined health risk.
 - vi. The patient has no evidence of a coexisting serious injury or systemic illness, newly discovered or progressive in nature.
 - vii. Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia or hypotension.
 - viii. The patient's clinical condition allows for a comprehensive and satisfactory assessment of items cited in clauses (i) -- (vii) of this subparagraph and paragraphs (A) -- (D).
 - C. Category 3: family, social, academic dysfunction. The patient must meet the criteria of at least one clause out of clauses (i) -- (iv) of this subparagraph.
 - i. The patient's social system and significant others are supportive of recovery to the extent that the patient can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the patient's addiction.
 - ii. The patient's family and/or significant others are willing to participate in the outpatient detoxification treatment program.
 - iii. The patient may or may not have a primary or social support system to assist with immediate recovery, but has the social skills to obtain such a support system and/or to become involved in a self-help fellowship.
 - iv. The patient's living environment should be considered as a factor. An individual living in an environment where licit or illicit mood altering substances are being used may not be a candidate for this level of care.
 - D. Category 4: emotional/behavioral status. The patient must meet all the criteria under clauses (i) -- (vii) of this subparagraph.

- i. Patient is coherent, rational and oriented for treatment.
 - ii. Mental state of the patient does not preclude the patient's ability to:
 - I. comprehend and understand the materials presented; and
 - II. participate in outpatient detoxification treatment process.
 - iii. There is documentation that the patient expresses an interest to work toward outpatient detoxification treatment goals .
 - iv. Patient has no neuropsychiatric condition that places the client at imminent risk of harming self or others (e.g. pathological intoxication, alcohol idiosyncratic intoxication, etc.),
 - v. Patient has no neurological, psychological, or uncontrolled behavior that places the individual at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, anxiety, etc.).
 - vi. Patient has no documented DSM-IV axis I condition or disorder which, in combination with alcohol and/or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the patient.
 - vii. The patient has no mental confusion and/or fluctuating orientation.
- E. Category 5: recent chemical substance use. The patient must meet the criteria in at least one clause out of clauses (i) and (ii) of this subparagraph.
- i. The patient's chemical substance use is excessive, and the patient has attempted to reduce or control it, but has been unable to do so (as long as chemical substances are available).
 - ii. The patient is motivated to stop using alcohol/drugs, and is in need of a supportive structured treatment program to facilitate withdrawal from chemical substances.

28 TAC s 3.8028

Continued stay criteria for outpatient detoxification treatment

- a. A patient is considered eligible for continued stay in the outpatient detoxification treatment service when the patient meets the diagnostic criteria and the conditions under at least one paragraph out of paragraphs (1) or (2) in subsection (b) of this section.
- b. Factors for continued outpatient detoxification treatment services are listed in paragraphs (1) and (2) of this subsection.
 - 1. Chemical substance withdrawal complications. The patient must meet the conditions of subparagraphs (A) or (B) of this paragraph.
 - A. Patient, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol/drugs, as evidenced by psychological and physical cravings.
 - B. Patient, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol/drugs, as evidenced by significant drug levels .
 - 2. Psychiatric or medical complications. Documentation in the record indicates an intervening medical or psychiatric event which was serious enough to interrupt outpatient detoxification treatment, but the patient is again progressing in treatment.

28 TAC s 3.8029

Discharge criteria for outpatient treatment service

The patient is no longer considered eligible for outpatient detoxification treatment service when the patient fails to meet the criteria for continued stay for outpatient detoxification treatment services, as addressed in s 3.8028 of this title (relating to Continued Stay Criteria for Outpatient Detoxification Treatment Service).

28 TAC s 3.8030

Recommended length of stay for outpatient detoxification treatment service

The recommended stay period for outpatient treatment services is from 5 to 10 days, with the understanding of the individual's dependency on high doses of sedative hypnotics or has been taking high doses of opiate medications or if individual is pregnant, may require longer than 10 days of outpatient detoxification based on the decision of the treating physician and based on the admission criteria for outpatient detoxification treatment services in s 3.8027 of this title (relating to Admission Criteria for Outpatient Detoxification Treatment Services) with utilization review points, based on continued stay criteria in s 3.8028 of this title (relating to Continued Stay Criteria for Outpatient Detoxification Treatment Service), and recommended treatment periods depending on the condition of the patient, accompanied by the commencement of appropriate utilization review and discharge planning at the time of admission.

Residential Treatment Position Statements

1. Managed Health Network (MHN) does not cover care provided in "Wilderness Residential Treatment" programs.
2. Managed Health Network (MHN) recommends that residential treatment provided by Out-of-Network programs be excluded from plan benefits.

Guidelines for Rapid Opioid Detoxification (ROD)

Managed Health Network (MHN) has adopted the following policy recommendations of the American Society of Addiction Medicine Board of Directors as MHN Guidelines:

1. Opioid detoxification alone is not a treatment of opioid addiction. ASAM does not support the initiation of acute opioid detoxification intervention unless they are part of an integrated continuum of services that promote ongoing recovery from addiction.
2. Ultra-Rapid Opioid Detoxification (UROD) is a procedure with uncertain risks and benefits, and its use in clinical settings is not supportable until a clearly positive risk-benefit relationship can be demonstrated. Further research on UROD should be conducted.
3. Although there is medical literature describing various techniques of Rapid Opioid Detoxification (ROD), further research into the physiology and consequences of ROD should be supported so that patients may be directed to the most effective treatment methods and practices.
4. Prior to participation in any particular modality of opioid detoxification, a patient should be provided with sufficient information by which to provide informed consent, including information about the risks of termination of a treatment plan of prescribed agonist medications such as methadone or buprenorphine, as well as the need to comply with medical monitoring of their clinical status for a defined period of time following the procedure to ensure a safe outcome. Patients should also be informed of the risks, benefits and costs of alternative methods of treatment available.

The full copy right protected text of the American Society of Addiction Medicine Board of Directors Policy Statement is attached:



detox for opiate.txt

Guidelines for When a Therapist Seeing More Than One Family Member at a Time in Outpatient Treatment

Psychotherapists shall carefully consider the potential conflict that may arise between the family unit(s) and each individual. Psychotherapists should clarify at the commencement of therapy which person or persons are clients and the nature of the relationship(s) the therapist will have with each person involved in the treatment. MHN recommends that a therapist have individual session with one member only as an adjunct to family treatment, and ongoing individual therapy for more than one family member should not, as a rule be authorized. If multiple members of the family are in need of treatment, there should be a family therapist to treat the unit and individuals in the family in need of ongoing treatment, should be referred to other MHN providers who should collaborate regularly with the designated primary therapist treating the family.

Guidelines for When a Therapist is Seeing a Member More Than Once Weekly in Outpatient Treatment

It is MHN's position that more than one session per week of outpatient therapy is for short term use only. It should be used on a brief basis at the treating providers discretion to address situations of heightened clinical acuity or scheduling logistics. Provision of more than one session a week does not need to be approved by MHN as long as the sessions themselves have already been authorized, however, the treating providers use of this increased intensity of care will be assessed when an MHN care manager considers the clinical justification for approval of additional requested services.

Special Considerations for the Child and Adolescent Population

1. MHN recognizes that children and adolescents have special conditions and treatment needs that are different from those of adults. Comprehensive treatment for this population requires extra resources to provide the following:
 - A nurturing environment suitable for this age group;
 - Proper facilities to pursue age-related activities;
 - Access to an appropriate educational program; and
 - Family involvement in treatment.
2. Learning and attention disorders are treated more appropriately with educational, family and medical interventions, if this is a covered benefit, rather than hospitalization.
3. Therapy at any level for children and adolescents requires a thorough evaluation of the family and/or support system dynamics, including a careful search for evidence of physical, sexual, or substance abuse.
4. Anti-social values or attitudes for which authoritarian restraint by parents or the juvenile justice system is appropriate may commonly drive disruptive behavior in adolescents. In other words, disruptive or sociopathic behavior in adolescents is not by itself a sufficient criterion for a mental disorder in this population.

Guidelines Regarding Member Self-Pay for Room and Board

MHN will authorize payment for medically necessary services at credentialed Partial Hospital and Intensive Outpatient programs, even when the member has chosen to self pay for room and board at a program that also offers Inpatient or Residential levels of care as long as these arrangements do not interfere with treatment at the Partial Hospital or Intensive Outpatient level of care .

Guidelines Regarding Treatment Delays Pending Court Ordered Treatment

MHN reviews requests for continued authorization of facility treatment for members where active, medically necessary treatment is delayed pending a court order for the treatment. A limited number of days (i.e. 2-3) may be authorized at the discretion of an MHN Medical Director in the interest of continuity of care when the facility is making reasonable efforts to secure the court order. For longer delays in active, medically necessary treatment, MHN's professional relations department will attempt to negotiate an "administrative rate" with the facility that will cover the basic room and board for the member awaiting the court order for treatment. Extended facility stays where active, medically justified treatment is delayed pending a court order for treatment will not be authorized by MHN for the full contract rate for treatment at that level of care.

Guidelines Regarding Dual/Multiple Relationships with Patients

Managed Health Network (MHN) recognizes that the relationship between practitioner and patient is central to the treatment process and is an important component to the patient's improvement. The practitioner's influence in this relationship, however, also has the potential of becoming exploitative and/or harmful. To prevent harm to patients caused by relationships that interfere with treatment, MHN expects practitioners to conform to the following standards:

- 1. Dual or multiple relationships :** In psychotherapy, a dual or multiple relationship exists when the practitioner relates to a patient in another context (e.g., financial, business, social, or other activities) that also involves a personal relationship. Such dual or multiple relationships can occur either simultaneously with treatment or during a reasonable period of time following termination. Practitioners will not engage in such relationships with patients if there is a risk of exploitation or harm to the patient. Practitioners will also avoid dual relationships by not accepting as patients people they supervise and by not supervising individuals whom they have formerly had as patients. MHN recognizes that not all dual relationships are harmful and that some cannot be avoided. In cases of unavoidable dual relationships, MHN expects practitioners to take appropriate precautions to ensure that there is no conflict of interest, exploitation, or factors that would impair professional judgment. It is the practitioner's responsibility to set clear, appropriate, and culturally sensitive boundaries to protect patients' well-being.
- 2. Sexual relationships :** A sexual relationship (including sexual intercourse, contact, or intimacy) with a patient, patient's relative, or an individual with whom the patient is interpersonally close, is prohibited during the course of treatment and for a period of at least two years following cessation of professional services. Practitioners will also not accept as patients individuals with whom they have formerly engaged in sexual intimacies. MHN further discourages practitioners from engaging in sexual relationships with persons over whom they have supervisory, evaluative, or other authority. The latter relationships are prohibited if they pose a risk to patient care or are prohibited by regulations related to a practitioner's license.
- 3. Conflicting roles:** When practitioners provide services to two or more individuals who have a relationship with each other (e.g., couples, family members), there is a risk of conflicting roles. In such cases, the practitioner makes every effort to avoid role conflict by clarifying his/her role to all parties involved and taking appropriate action to minimize any conflict of interest. This issue is of particular concern in legal proceedings (e.g., divorce, custody disputes). Although a prior professional relationship does not preclude a practitioner from testifying as a fact witness or as to services provided, the practitioner must take into account ways in which the prior relationship might affect professional objectivity. Prior to offering testimony, the practitioner must disclose the potential conflict to all relevant parties.

Guidelines for Higher Levels of Care

1. Clinical evidence suggests that the psychosocial stressors precipitating this admission are being actively addressed and that the psychosocial interventions are likely to impact either the patient or his/her living condition within a brief period of time.
2. Patient and family/significant others are compliant with acute treatment plan to the extent possible. Family treatment is included in the treatment plan as appropriate.
3. Program is actively pursuing discharge planning to ensure continued treatment occurs at the least restrictive level of care possible.
4. The focus of the initial treatment plan has been updated to account for clinical changes and identify medical, substance abuse or psychiatric co-morbidity.
5. The treatment plan is being implemented in a timely manner. The treatment plan remains focused on objectively measurable goals and is time limited.
6. There is little evidence that the current treatment plan is effective. There is no appropriate alternate treatment plan proposed. Further progress with the present plan is deemed unlikely.

Guidelines for Outpatient Care of Children and Adolescents

1. Parent(s) or guardian are being educated and are participating actively in the treatment process, where appropriate. Efforts are being made to enhance family functioning and the ability of parents or guardians to help manage the patient's psychiatric disorder.
2. Outpatient psychotherapy may be used to address acute symptoms or to help patients maintain their level of function in the presence of chronic illness. Psychotherapy should have clear goals of treatment that will reduce the risk of danger to self and others, optimize functioning and return the patient to his/her baseline developmental tract, and reduce the likelihood of requiring future treatment at a higher levels of care.
3. Medical necessity could be evaluated through attempts to increase the time interval between visits.

Guidelines for Precluding Further Outpatient Certification

1. The symptoms that necessitated treatment are significantly reduced and those targets set at the beginning of treatment have been achieved, and/or there has been an improvement in the general level of function back to baseline.
2. The probability of successful outcome with continued treatment at this level is seriously compromised because patient and/or significant others are not compliant with the treatment recommendations. Examples may include, but are not limited to: active substance abuse, refusing medications or psychiatric consultation when clinically indicated, poor attendance, and/or failure to readily engage in the treatment process.
3. There is little evidence that the current treatment plan is effective. There is no appropriate alternate treatment plan proposed. Further progress with the present plan is deemed unlikely.

Custodial Care

Custodial means care rendered when:

1. The condition is one for which no known effective treatment exists; or
2. An active treatment program has not demonstrated significant impact on the patient's illness, and no new treatment interventions or a change in treatment strategy is anticipated or considered feasible

Medical Necessity

Except where state or federal law or regulation requires a different definition, MHN shall apply the following definition of “Medically Necessary” or comparable term in each agreement with Physicians, Physician Groups, Physician Organizations, and all other providers, and will not include in any such agreement a definition of Medical Necessity that is different from this definition:

“**Medically Necessary**” or “**Medical Necessity**” shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (A) in accordance with generally accepted standards of medical practice;
- (B) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- (C) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents.

When considering whether a service or treatment is “experimental or investigational” if such service or treatment is Medically Necessary as defined above said service or treatment will be paid for unless specifically excluded from coverage in the Plan.