NMNC 1.101.04 Inpatient Psychiatric Services

Acute Inpatient Psychiatric Services are the most intensive level of psychiatric treatment used to stabilize individuals with an acute, worsening, destabilizing, or sudden onset psychiatric condition with a short and severe duration. A structured treatment milieu and 24-hour medical and skilled nursing care, daily medical evaluation and management, (including a documented daily visit with an attending licensed prescribing provider), and structured milieu treatment are required for inpatient treatment. Treatment may include physical and mechanical restraints, isolation and locked units.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 – 4 must be met and either 5 or 6 must be met; criteria 7, 8 or 9 must be met as applicable to a member's unique condition; for Eating Disorders, criteria 10 – 13 must also be met in addition to the preceding criteria requirements: 1) Symptoms consistent with a *DSM* or corresponding ICD diagnosis; and 2) Member's psychiatric condition requires 24-hour medical/ psychiatric and nursing services and is of such intensity that needed services can only be provided in an acute psychiatric hospital; and; 3) Inpatient psychiatric services are expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed; and; 4) Symptoms do not result from a medical condition that would be more appropriately treated on a medical/surgical unit; and 5) Danger to self (**one of the following**) a. a serious suicide attempt by degree of lethality and intentionality; suicidal ideation with plan and means; and/or history of prior serious suicide attempt; or b. suicidal ideation accompanied by severely depressed mood, significant losses, and/or continued intent to harm self; or c. command hallucinations or persecutory delusions directing self-harm; or d. loss of impulse control resulting in life-threatening behavior or danger to self; or e. significant weight loss within the past three months; or f. self-mutilation that could lead to permanent disability; or g. uncontrolled risk-taking behaviors or 6) Danger to others: Homicidal ideation and/or indication of actual or potential danger to others (**one of the following**) a. command hallucinations or persecutory delusions directing harm or	**Criteria 1 – 10 must be met; for Eating Disorders, criterion 11 or 12 must also be met in addition to the preceding criteria requirements:** 1) Member continues to meet admission criteria 2) Another less restrictive level of care would not be adequate to administer care; 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require rapid re-hospitalization 4) Treatment is still necessary to reduce symptoms and improve functioning so that the member may be treated in a less restrictive level of care; 5) There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment continuing in a less restrictive level of care 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out; treatment plan has been updated to address non-adherence; 7) Member is actively participating in plan of care and treatment to the extent possible consistent with his/her condition	**Any *one* of the following criteria must be met: 1, 2, 3, 4 or 5; criteria 6 and 7 are recommended, but optional; for Eating Disorders, criteria 8 – 10 must be met:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; or 2) Member or parent/guardian withdraws consent for treatment *and/or* member does not meet criteria for involuntary or mandated treatment; or 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress; or 5) Member's physical condition necessitates transfer to a medical/surgical facility 6) Member's individual treatment plan and goals have been met 7) Member's support system is aware and in agreement with the aftercare treatment plan ***For Eating Disorders** 8) Member has reached at least 85%

potential violence to others; or b. indication of danger to property evidenced by credible threats of destructive acts; or c. documented or recent history of violent, dangerous, and destructive acts 7) Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning 8) Evidence of severe disorders of cognition, memory, or judgment are not associated with a primary diagnosis of neurocognitive disorder (dementia) or other cognitive disorders (e.g., acute psychotic symptoms) 9) Severe comorbid substance use disorder is present and must be controlled (e.g., abstinence necessary) to achieve stabilization of primary psychiatric disorder ***For Eating Disorders: Weight alone should not be the sole indicator of admission, continued stay, or discharge.** 10) *DSM*/ICD diagnosis and symptoms consistent with a primary diagnosis of Eating Disorder 11) Member has **at least one** of the following: a. psychiatric, behavioral, and eating disorder symptoms that are expected to respond to treatment in an acute level of care; or; b. symptomatology that is not responsive to treatment in a less intensive level of care; or; c. an adolescent with newly diagnosed anorexia. 12) Member requires 24-hour monitoring, which includes: before, after, and during meals; evening to monitor behaviors (i.e.,. restricting, binging/purging, over- exercising, use of laxatives or diuretics) 13) Member exhibits physiological instability requiring 24-hour monitoring for at least **one of the following:** a. rapid, life-threatening and volitional weight loss not related to a medical illness: generally, <80% of IBW (or BMI of 15 or less); electrolyte imbalance; or b. physiological liability (i.e., significant postural hypotension, bradycardia, CHF, cardiac arrhythmia); or c. change in mental status; or d. body temperature below 96.8 degrees; or e. severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement; or	8) Family/guardian/caregiver is participating in treatment as appropriate; 9) There is documentation of coordination of treatment with state or other community agencies, if involved 10) Coordination of care and active discharge-planning are ongoing, beginning at admission with goal of transitioning the member to a less intensive level of care ***For Eating Disorders** 11) Member has had no appreciable weight gain (<2lbs/wk.) 12) Ongoing medical or refeeding complications	ideal body weight and has gained enough weight to achieve medical stability (e.g., vital signs, electrolytes, and electrocardiogram are stable) 9) No re-feeding is necessary 10) All other psychiatric disorders are stable (do not require this level of care)

f. acute gastrointestinal dysfunction (i.e., esophageal tear secondary to vomiting, megacolon or colonic damage due to self -administered enemas); or g. heart rate is less than 40 beats per minute for adults or near 40 beats per minute for children		

Exclusions

Any **one** of the following criteria is sufficient for exclusion from this level of care*:*

1) Member can be safely maintained and effectively treated at a less intensive level of care; or
2) Symptoms result from a medical condition that warrants a medical/surgical setting for treatment; or
3) Member exhibits serious and persistent mental illness **and** is not in an acute exacerbation of the illness; or
4) Primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration

Reference sources

Beacon's Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA)
2) National care guideline and criteria entities: MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH)
4) Professional publications and psychiatric texts: [Beacon's Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)