NMNC 3.302.03 Intensive Outpatient Treatment

Intensive Outpatient Programs (IOP) offer short-term, multidisciplinary, structured day or evening programming that consists of intensive treatment and stabilization within an outpatient therapeutic milieu setting. IOP must be available at least 3 – 5 days per week, typically 2 – 3 hours per day. Treatment reduces in intensity and frequency as the member establishes community supports and resumes daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long-term day treatment. IOPs may be provided by either hospital-based or freestanding outpatient programs to members who experience symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive level of care. These programs also include 24/7 crisis management services, individual, group, and family therapy and coordination of medication evaluation and management services, as needed. Coordination with collateral contacts and care management/discharge planning services should also occur regularly as needed in an IOP. For children and adolescents, the IOP provides services similar to an acute level of care for those members with a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child's caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All* of the following criteria 1 – -7 must be met; for Eating Disorders criteria, 8 – 10 must also be met in addition to the preceding seven.** 1) Symptoms consistent with a *DSM* or corresponding ICD diagnosis 2) Member is determined to have the capacity and willingness to improve or stabilize as a result of treatment at this level 3) Member has significant impairment in daily functioning due to psychiatric symptoms or comorbid substance use of such intensity that the member cannot be managed in routine outpatient or lower level of care 4) Member is assessed to be at risk of requiring a higher level of care if not engaged in intensive outpatient treatment 5) There is indication that the member's psychiatric symptoms will improve within a reasonable time period so that the member can transition to outpatient or community-based services 6) Member's living environment offers enough stability to support intensive outpatient treatment 7) Member's psychiatric/substance use/biomedical condition is sufficiently stable to be managed in an intensive outpatient setting **For Eating Disorders*: Weight alone should not be the sole criteria for admission or discharge.**	***All* of the following criteria must be met; for Eating Disorders, criteria 11 or 12 must also be met in addition to the first 10:** 1) Member continues to meet admission criteria 2) Another less intensive 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 a more intensive level of care 4) Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less intensive level of care 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out 6) There is an individualized treatment plan that is focused on addressing the factors leading to admission and evidence suggests that the identified problems are likely to respond to current treatment plan 7) Member's progress is monitored regularly. The treatment plan is modified, if the member is not making substantial progress towards clearly defined and measurable goals.	**Any *one* of the following criteria 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) Parent or guardian withdraws consent for treatment or the Member is unwilling or unable to participate in treatment, and involuntary treatment or guardianship is not being pursued; or 3) Member does not appear to be participating in the treatment plan despite multiple documented efforts to engage the member; or 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met, and when indicated, member's support systems are in agreement

8) Any monitoring of member's condition when away from intensive outpatient program can be provided by family, caregivers, or other available resources 9) Member exhibits symptoms consistent with an eating disorder diagnosis and requires at least *one* of the following: a) as a result of eating disorder behaviors, weight stabilization: generally, between 80 and 85% of IBW (or BMI 15-17) is needed*; **or** b) frequent supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight loss behavior such as caloric restriction, intake refusal, voluntary vomiting or excessive exercise; **or** c) member misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) cannot be treated at a lower level of care. 10) Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require medical intervention in a higher level of care	8) Family/guardian/caregiver is participating in treatment as appropriate 9) There is documentation around coordination of treatment with collaterals and other providers when appropriate 10) Provider has documentation supporting discharge-planning attempts to transition the member to a less intensive level of care **For Eating Disorders*** 11) Member has had no appreciable stabilization of weight since admission or there is continued instability in food intake despite weight gain; or 12) The eating disorder behaviors persist and continue to put the member's medical status in jeopardy	with the aftercare treatment plan; or **For Eating Disorders*** 6) Member has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care

Exclusions

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

1) Member is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required; or
2) Member can be safely maintained and effectively treated at a less intensive level of care; or
3) Member or guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment
4) Member requires a level of structure and supervision beyond the scope of the program; or
5) Member has medical conditions or impairments that would prevent beneficial utilization of services; or
6) Primary problem is social, custodial, economic (i.e., 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; or
7) Main purpose of the admission is to provide structure that may otherwise be achieved via community-based or other services to augment vocational, therapeutic or social activities; or
8) Treatment plan is designed to address goals other than the treatment of active symptoms consistent with a *DSM* or corresponding ICD diagnosis (e.g., self-actualization)

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); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see 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)