BlueCross BlueShield of North Carolina

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Corporate Medical Policy

Residential Treatment

File Name:	residential_treatment
Origination:	7/1999
Last CAP Review:	6/2019
Next CAP Review:	6/2020
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Description of Procedure or Service

A residential treatment facility is a 24-hour facility that is not a hospital, but which offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their psychiatric treatment, eating disorder, or to their chemical dependency or addiction to drugs or alcohol. These programs are comprehensive and address potential symptoms/behaviors and incorporate psychotherapeutic treatments and education through a multidisciplinary team approach. The treatment plan is individualized and intensive, offering individual therapy, family counseling, group therapy, and recreational activities. The program will generally offer a prolonged after-care component and facilitates peer support. The patient must meet medical necessity criteria for admission into a residential facility.

Most residential treatment facilities provide limited direct MD or Ph.D. patient care. Facility-employed counselors provide most care, which is included in the daily costs. A physician or psychiatrist should evaluate the patient within the first 24 hours. Continuous assessment of the patient's need for continued residential treatment must be made by a physician or psychiatrist. This level of care is determined by matching the patient's status and needs to recover and regain the highest level of function to the appropriate level of care.

Residential treatment facilities are not for "providing housing", custodial care, a structured environment whose use is simply to change the person's environment, or a wilderness center training camp.

Related Policy:
Drug Testing in Pain Management and Substance Abuse Treatment

Policy

BCBSNC will provide coverage (subject to benefit limitations) for Residential Treatment when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

This policy may not apply to members whose coverage is exempt from Federal mental health parity.

When residential treatment is covered

CRITERIA FOR ADMISSION FOR CHEMICAL DEPENDENCE:

Criteria for admission of an adult require that **all** of the criteria cited under "Severity of Need" and under "Intensity of Service" must be met. Structured professional outpatient treatment and rehabilitation in the individual's normal setting is the treatment of choice. However, Residential Treatment, when indicated, should meet the following criteria:

- It should be individualized and not consist of a standard, pre-established number of days; and
- It should be the lowest level of care where treatment can safely and effectively be provided given the severity of the individual's condition.

A. Severity of Need
   1. The patient has a substance-related disorder as defined by a DSM-5 diagnosis that is amenable to active behavioral health treatment.
   2. The patient has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.
   3. The patient exhibits a pattern of moderate or severe substance use and/or addictive disorder as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
   4. There is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable and related to current abuse of substances such as medical and physical instability which would prohibit safe treatment in a less-intensive setting.
   5. One of the following must be met:
      a. despite recent (i.e., the past 3 months), appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, or
      b. the patient is residing in a severely dysfunctional living environment which would undermine effective outpatient treatment at a less-intensive level of care and alternate living situations are not available or clinically appropriate, or
      c. there is clinical evidence that the patient is not likely to respond at a less-intensive level of care.
   6. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care. The patient does not have significant co-morbid condition(s).
   7. The patient demonstrates motivation to manage symptoms or make behavioral change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

B. Intensity and Quality of Service
   1. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face behavioral health evaluation within the past 48 hours by a psychiatrist or an Addiction Medicine Physician. The patient has been determined to be medically and psychiatrically stable. With the geriatric patient, as part of the mental status testing, assessment of cognitive functioning is required with standardized screening tools for cognitive assessment.
   2. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
   3. Treatment includes at least once-a-week psychiatric reassessments, if indicated.
   4. Additionally, there is sufficient availability of medical and nursing services to manage this patient's ancillary co-morbid medical conditions.

5. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.
6. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction.
7. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and licensed registered nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Criteria for admission for a Child or Adolescent:

A. Severity of Need:
   1. In addition to the above criteria, the child or adolescent is capable of developing skills to manage symptoms or make behavioral change.

B. Intensity and Quality of Service
   1. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face behavioral health evaluation within the past 48 hours by a psychiatrist or an Addiction Medicine Physician. The patient has been determined to be medically and psychiatrically stable.
   2. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
   3. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and licensed registered nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
   4. Treatment includes at least once-a-week psychiatric reassessments, if indicated.
   5. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.
   6. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction.

CRITERIA FOR CONTINUED STAY FOR CHEMICAL DEPENDENCE:

All the criteria listed below must be met to satisfy criteria for continued stay:

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
   1. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
   2. The emergence of additional problems that meet the admission criteria)both severity of needs and intensity of service needs), or
   3. That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion “A”, and the patient’s progress is

documented by the provider at least 3 times per week. This plan receives regular reviews and revisions that include ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.

C. There is evidence of regular caretaker'/guardians'/family members' involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regiment or other requirements of treatment.
E. A discharge plan is formulated this is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.
F. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

CRITERIA FOR ADMISSION FOR PSYCHIATRIC RESIDENTIAL TREATMENT

Criteria for admission of an adult require that **all** of the criteria cited under "Severity of Need" and under "Intensity of Service" must be met. Structured professional outpatient treatment and rehabilitation in the individual's normal setting is the treatment of choice. However, Residential Treatment, when indicated, should meet the following criteria:

- It should be individualized and not consist of a standard, pre-established number of days; and
- It should be the lowest level of care where treatment can safely and effectively be provided given the severity of the individual's condition.

A. Severity of Need
   1. There is clinical evidence that the patient has a DSM-5 disorder that is amenable to active psychiatric treatment, AND
   2. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment, AND
   3. Either:
      a. There is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program, ***or***
      b. As a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self, AND
   4. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential setting, AND
   5. The patient's current living environment does not provide the support and access to therapeutic services needed, AND
   6. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

B. Intensity and Quality of Service
   1. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation. With the geriatric patient, cognitive functioning is warranted as part of the mental status testing assessment, AND
   2. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting, AND
   3. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with

24-hour medical availability and 24-hour onsite nursing services. This plan includes:

a. Weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, AND
b. Psychotropic medications, when used, are to be used with specific target symptoms identified, AND
c. Evaluation for current medical problems or ongoing medical services to evaluate and manage co-morbid medical conditions, AND
d. Evaluation for concomitant substance use issues, AND
e. Integrated treatment, rehabilitation and support provided by a multidisciplinary team, AND
f. Linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. For children/adolescents, school contact should address Individualized Educational Plan/s as appropriate. AND

4. The care is expected to include availability of activities/resources to meet the social needs of older patients with chronic mental illness. These needs would typically include at a minimum company, daily activities and having a close confidant, AND
5. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

CRITERIA FOR CONTINUED STAY FOR PSYCHIATRIC RESIDENTIAL TREATMENT

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
    1. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), ***or***
    2. The emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), ***or***
    3. That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment, AND
B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation, AND
C. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed, AND
D. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care, AND
E. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion A, and this is documented in weekly progress notes, written and signed by the provider, AND
F. There is evidence of weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, AND

G. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources, AND
H. All applicable elements in Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

CRITERIA FOR ADMISSION FOR EATING DISORDERS:

A. Severity of Need
If patient has anorexia, criteria 1, 2, 3, 4, 5, and 6 must be met to satisfy the criteria for severity of need. If patient has bulimia or Unspecified Eating Disorder, criteria 1, 2, 3, 4, and 7 must be met to satisfy the criteria for severity of need.
1. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Unspecified Eating Disorder. There is clinical evidence that the patient's condition is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of residential treatment. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorder residential level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.
2. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.
3. The patient's eating disordered behavior is not responding to an adequate trial of treatment in a less-intensive setting (e.g., partial hospitalization or intensive outpatient) *or* there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in a less-intensive setting than residential, the patient must:
   - Be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *and*
   - Have significant impairment in social or occupational functioning, *and*
   - Be uncooperative with treatment (or cooperative only in a highly structured environment), *and*
   - Require changes in the treatment plan that cannot be implemented in a less-intensive setting.
4. The patient's current living environment has severe family conflict and/or does not provide the support and access to therapeutic services needed. Specifically there is evidence that the patient needs a highly structured environment with supervision at or between all meals or will restrict eating or binge/purge. Additionally, the family/support system cannot provide this level of supervision along with a less-intensive level of care setting,
5. If a patient has anorexia, and has a body weight less than 85% of Ideal Body Weight (IBW). If body weight is equal to or greater than 85% of IBW, this criterion can be met if there is evidence of any one of the following:
   a. Weight loss or fluctuation of greater than 10% in the last 30 days, *or*
   b. The patient is within 5 – 10 pounds of a weight at which physiologic instability occurred in the past, *or*
   c. A child or adolescent patient rapidly losing weight and approaching 85% of IBW during a period of rapid growth.
6. In anorexia, the patient's malnourished condition requires 24-hour residential staff intervention to provide interruption of the food restriction, excessive exercise, purging, and/or use of laxatives/diet pills/diuretics to avoid imminent further weight loss or to continue weight gain from a recent hospital level of care.

7. In patients with bulimia or eating disorder not otherwise specified, the patient's condition requires 24-hour residential staff intervention to provide interruption of the binge and/or purge cycle to avoid imminent, serious harm due to medical consequences *or* to avoid imminent serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation).

B. Intensity and Quality of Service
   1. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family members and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible, AND
   2. The program provides supervision seven days per week/24 hours per day to assist with the development of internal controls to prevent excessive food restricting, binging, purging, exercising and/or use of laxatives/diet pills/diuretics. The program also assists with planning and arranging access to a range of educational, therapeutic and aftercare services and assists with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting, AND
   3. An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
      a. at least weekly family and/or support system involvement, unless there is an identified valid reason why it is not clinically appropriate or feasible, *and*
      b. psychotropic medication, if medically indicated, to be used with specific target symptoms identified, *and*
      c. evaluation and management for current medical problems, *and*
      d. evaluation and treatment for concomitant substance abuse issues, *and*
      e. linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.

CRITERIA FOR CONTINUED STAY FOR EATING DISORDERS

Criteria A, B, C, D, E, F, G, and H must be met to satisfy the criteria for continued stay. Additionally, if anorectic, criterion I must also be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
   1. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*
   2. The emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
   3. That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued residential treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment plan is focused on the eating disorder behaviors and precipitating psychosocial stressors that are interfering with the patient's ability to participate in a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion A, and this is documented in daily progress notes, written and signed by the provider.
E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
F. There is evidence of a continued inability to adhere to a meal plan and maintain control over restricting of food or urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required.
G. A discharge plan is formulated that is directly linked to the eating behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential services.
H. All applicable elements in Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.
I. If anorectic, the patient's weight remains less than 85% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.

When residential treatment is not covered

Residential treatment is not covered for the use of foster homes or halfway houses.

Residential treatment is not covered for Wilderness Center training.

No benefits are available for custodial care, situation or environmental change.

Residential treatment is considered not medically necessary when the above criteria for admission or continued stay (Chemical Dependence, Psychiatric residential treatment, or Eating Disorders) are not met.

Policy Guidelines

Admission to a residential facility requires precertification.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: *No specific code*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 1998

North Carolina General Statute §58-65-75 (Comprehensive Major Medical and PPO policies)

North Carolina General Statute §58-67-70 (HMO and POS policies)

Medical Policy Advisory Group - August 12, 1999

Specialty Matched Consultant Advisory Panel - 9/2000

Medical Policy Advisory Group - 10/2000

Specialty Matched Consultant Advisory Panel - 9/2002

Specialty Matched Consultant Advisory Panel - 8/2004

Specialty Matched Consultant Advisory Panel - 8/2006

Specialty Matched Consultant Advisory Panel – 7/2012

Specialty Matched Consultant Advisory Panel – 7/2013

American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders, 2nd edition. In American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. Arlington, VA: American Psychiatric Association, 2006 (pp. 291–563). Available online at http://www.psych.org/psych_pract/treatg/pg/SUD2ePG_04-28-06.pdf.

American Psychiatric Association (2006). Treating Substance Use Disorders: A Quick Reference Guide.

Kleber HD & Smith Connery H. (2007). Guideline Watch (April 2007): Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Edition. FOCUS: The Journal of Lifelong Learning in psychiatry V(2):1-4, Spring 2007.

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 2014

Specialty Matched Consultant Advisory Panel – 7/2014

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 2015

Specialty Matched Consultant Advisory Panel – 7/2015

Policy Implementation/Update Information

7/99	Local Policy issued.
8/99	Medical Policy Advisory Group reaffirmed
8/99	Reformatted, Medical Term Definitions added.
10/00	Specialty Matched Consultant Advisory Group review. No change recommended in criteria. System coding changes. Medical Policy Advisory Group review. No change in criteria. Approve.
2/02	Formatting change.
11/02	Specialty Matched Consultant Advisory Panel review 9/2002. No changes.
8/26/04	Specialty Matched Consultant Advisory Panel review 8/4/2004. Revised Description of Procedure or Service section. No changes to criteria. Updated Benefit Application, Policy Guidelines, and Billing/Coding sections for consistency. References added.
9/23/04	Updated Last Review Date and Next Review Date.
8/28/06	Specialty Matched Consultant Advisory Panel review 8/1/2006. No changes to policy statement. Policy status changed to: "Active policy, no longer scheduled for routine literature review". References added. (btw)
6/22/10	Policy Number(s) removed (amw)

8/7/12	Specialty Matched Consultant Advisory Panel review 7/18/12. No changes to policy statement. Policy returned to Active status. (sk)
3/11/14	Specialty Matched Consultant Advisory Panel review 7/17/13. No changes to policy statement. References added. (sk)
11/11/14	Specialty Matched Consultant Advisory Panel review 7/29/14. Added admission criteria and continued stay criteria for Psychiatric Residential Treatment and Eating Disorders Residential Treatment. Reference added. Clarified that Residential Treatment is not covered unless criteria are met. Title changed to Residential Treatment. Medical Director review. (sk)
9/1/15	Specialty Matched Consultant Advisory Panel review 7/29/15. Reference added. (sk)
8/30/16	Criteria for admission and continued stay in residential treatment for chemical dependency extensively revised for clarity. Specialty Matched Consultant Advisory Panel review 7/27/2016. Policy intent unchanged. (an)
7/28/17	Specialty Matched Consultant Advisory Panel review 6/28/2017. No change to policy statement. (an)
7/27/18	Specialty Matched Consultant Advisory Panel review 6/27/2018. No change to policy statement. (an)
7/30/19	Specialty Matched Consultant Advisory Panel review 7/10/2019. No change to policy statement. (eel)