

Behavioral Health Services Level of Care Determination

[Admin-003 Medical Services Level of Care Determination](#)

Policy Admin-002

Origination Date: 04/06/2018

Reviewed/Revised Date: 07/28/2021

Next Review Date: 07/28/2022

Current Effective Date: 07/28/2021

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.

Description:

University of Utah Health Plan (U of U Health Plans) applies clinical criteria using the philosophy that the most appropriate level of care for patients should be the safest and least restrictive possible. The goal of treatment is to restore the patient to an optimal level of functioning and independence. Application of these criteria takes into consideration the fact that individual patients vary in their level of clinical complication, and that the full continuum of clinical services does not exist in all geographic areas. Under circumstances of patient complexity or limited service availability, a recommendation to a higher level of care than medically necessary in order to ensure safe, effective treatment may occur. These criteria apply to both behavioral health and substance abuse admissions.

Policy Statement and Criteria

1. Commercial Plans

The hierarchy of consideration for determining the level of care for Medical Services is as follows:

- A. SPD coverage exclusions or limitations
- B. Internal U of U Health Plans policies
- C. InterQual® criteria for determining medical necessity for the following levels of care:
 - i. Acute inpatient services
 - ii. Partial Hospitalization
 - iii. Intensive Outpatient (IOP)
 - iv. Residential Treatment (RTC)

- D. If no guidance is provided in InterQual, SPD, or CMS guidelines or if an exception is requested for a certain level of care (inpatient – outpatient, outpatient to inpatient, RTC, etc.) outside the standards defined by InterQual, the cases are sent to physician review for consideration of granting an exception based on comorbidities and other clinical considerations.

Administrative policy #003 Medical Services Level of Care Determination outlines the level of care determination of care criteria for medical services.

2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at

<http://health.utah.gov/mc/mcmanuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

3. Medicare Plans

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, U of U Health Plans' commercial policies would apply. For the most up-to-date Medicare policies and coverage, please visit their search website at:

<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#).

Clinical Rationale

The term “Medical Necessity” is used to mean care that is determined to be effective, appropriate and necessary to treat a given patient’s disorder.

Each level of care is indicated as either for psychiatric or substance use disorders (except for the outpatient level of care, which includes both), and review for level of care determination proceeds in a logical progression to confirm:

- The presence of a properly diagnosed psychiatric or substance use disorder amenable to treatment,
- Symptoms of sufficient severity to meet the required criteria for admission,
- The illness by accepted medical standards is expected to improve significantly through medically necessary and appropriate care as it relates to the level of care requested, and
- Clinical requirements for continuing care at that level.

Discharge criteria, program content, treatment interventions, etc., are not included in an attempt to avoid being too prescriptive and preempting clinical discourse. Therefore, determinations for discharge from a given level of care are clear: when the patient no longer appears to meet the required criteria for continuing care at a given level of acuity, discharge to a lower level of care is recommended.

U of U Health Plans has adopted the “Patient Practice Guidelines” from the American Society of Addiction Medicine, ASAM PPC-2R, to guide authorization decision making for patients with substance use disorders. Now in its third edition, ASAM Criteria is the most widely used and comprehensive national guideline for placement continued stay and discharge of patients with alcohol or other drug problems.

Applicable Coding

No applicable codes

References:

1. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-V) American Psychiatric Association.
2. American Society of Addiction Medicine, Inc. Patient Placement Criteria for the Treatment or Substance Related Disorders, Third edition. Maryland: American Society of Addiction Medicine.

Disclaimer:

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member’s individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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