HEALTH PLANS
UNIVERSITY OF UTAH

Administration Policy

Behavioral Health Residential Treatment Centers

Policy ADMIN-004

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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, CHIP and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.
5. Provisions and terms of the provider contract may supersede this policy.

Description:

Behavioral Health Residential Treatment Centers (BHRTC) is a non-hospital facility that provides non-acute, 24-hour specialized inpatient treatment for members who have behavioral health, substance use, or eating disorders.

There is a wide range of public and private-sector residential programs for behavioral health conditions including offering residential care to adults with serious behavioral health disorders, combined with substance abuse. All provide a 24-hour supervision, drug and alcohol-free environment, along with professional or peer support. Residential care addresses those aspects of patients' prior living environment that contribute to their potential for relapse.

Behavioral health residential treatment provides an alternative point of care for patients who have experienced recurrent problems related to their behavioral health condition and require a more structured or intensive environment to overcome the acute problems from the less productive route that typically starts with a hospital stay. After managing the acute crisis that triggers the admission, hospitals may not offer patients enough structure. Also, the typical behavioral health hospital stay is often not long enough for some patients to develop the necessary skills and habits to function well in an outpatient environment.

Policy Statement and Criteria

1. Commercial Plans/CHIP

U of U Health Plans covers services provided in a behavioral health residential treatment center when the member and facility meets minimum standards.

Required Minimum Standards for Coverage of BH RTC Services (All Must be Met):

A. The program is individualized and doesn't consist of standard number of days;

B. The residential program is deemed appropriately able to manage the members' behavioral health and/or substance use disorder with evidence-based programming;

C. Without residential treatment the severity of the members' behavior and/or substance use disorder is likely to lead to inpatient hospitalization;

D. Behavioral health evaluation, initial within 1 business day, subsequent at least 1x/week;

E. Psychosocial assessment and substance evaluation within 48-hours;

F. Medical history and physical examination;

G. Nursing staff on-site/on-call 24-hours;

H. Clinical assessment at least 1x a day;

I. Medication administration/supervision at least 1x a Day;

J. Provides the following services:

   i. Individual therapy at least 1x a week;

   ii. Family therapy 1x a week (2 times a week for children only);

   iii. Group therapy at least 1x a day;

   iv. Structured therapeutic program at least 8 hours a day, 5 days per week;

   v. Accommodations for continuing education of school aged members recognized by an educational accreditation organization such as the State Board of Education or the National School Accreditation Board;

   vi. Indoor space for free and informal client activities.

K. On-site supervision 24-hours a day;

L. Toxicology screen/self-help/12-Step/education group as needed;

M. Preliminary discharge planning initiated within 72-hours;

N. Residential treatment center is provided in reasonable proximity to a members community or residence and support system;

O. Process in place to assure seven day post-residential treatment follow-up appointment is scheduled before discharge.

U of U Health Plans provides coverage of residential care treatment continued stay in a residential treatment program when the following criteria are met:

A. The member continues to meet the criteria for admission to the residential program.

B. There is reasonable evidence upon review that the treatment being provided for the behavioral health or substance use disorder will produce sustained benefit at discharge.

C. There is evidence that the treatment plan is being updated on a reasonable frequency to accommodate for changes in the members' condition, psychosocial stressors, and other factors that may interfere with the members' ability to return to a lower level of care.

D. Ongoing treatment plans demonstrate updated, objective and measurable goals reflective of members current state designed to help the member prepare for a safe transition to a lower level of care.

E. The submitted documentation demonstrates the member continues to be actively engaged in all aspects of the treatment. If the member is not participating, a documented intervention plan on how the treatment team is addressing the lack of engagement must be submitted.

F. Evidence should demonstrate weekly support system involvement unless there is a clinically appropriate and documented reason. This can be done in person or via telehealth means.

G. The submitted documentation shows the member is making clinically meaningful and measurable improvements in the behaviors or issues prompting the need for RTC care.

H. On-going discharge planning as evidenced by attempting to ensure appropriate housing, access to medically indicated care, plan linked to behaviors/symptoms that led to admission, and contingency plans in anticipation of eventual discharge.

U of U Health Plans <u>does NOT cover</u> the following residential treatment/service enters (Including but not limited to):

A. **Therapeutic Group Homes:** These are professionally-directed living facilities with behavioral health consultation available as needed. Group homes serve broad and varied patient populations with significant individual and/or family dysfunctions.

B. **Therapeutic Day Schools:** These are for students who struggle in a standard academic setting and who may have fallen behind due to emotional, behavioral or other psychological challenges. Some are boarding schools and others are schools where students are only on campus to attend class during the day.

C. **Therapeutic Boarding Schools:** The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological

and psychiatric services. These facilities may serve varied populations of students, many of which also have difficulties in social and academic areas. These programs generally do not have specialized nurses on site and/or a psychiatrist available at all times to assist with medical issues/crisis intervention and medication administration as needed.

D. **Wilderness Programs, Boot Camps, and/or Outward Bound Programs:** "At times state statute defines 'boot camps' or 'wilderness therapy programs' as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most of the 'boot camps' and 'wilderness programs' do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child's care. Also, the Joint Commission nearly universally denies certification for these types of programs that fail to meet the quality of care guidelines for medically supervised care from licensed mental health professionals."

E. **Community Alternatives:** The admission is being used for purposes of convenience or as an alternative to incarceration or simply as respite or housing.

F. **Environmental Admissions:** Admission and/or continued stay at this level of care is not justified when primarily for the purpose of providing a safe and structured environment, due to a lack of external supports, or because alternative living situations are not immediately available.

G. **Custodial Care:** Custodial care is defined by the Centers for Medicare and Medicaid services as care that assists an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

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: https://medicaid.utah.gov/utah-medicaid-official-publications/ or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Clinical Rationale

Behavioral Health Residential Treatment Centers (BHRTC) are live-in facilities providing therapy for substance abuse, mental illness, or other behavioral problems. These are less intensive than inpatient facilities such as hospitals, but the treatment in longer term. Their home-like atmosphere may help patients build self-esteem, develop relationships, and improve skills. At the same time, patients benefit from intense, professional treatment that is provided daily on-premises. Treatment can include individual psychotherapy, group therapy, vocational/educational counseling and support, and treatment for co-occurring addictions. Because clinicians treat patients where they live, they see the full picture of a patient's functioning and use that perspective and insight to fine-tune therapy.

Vandevooren et al. evaluated outcomes for participants of a community-based residential treatment and rehabilitation program. The study used repeated measures to retrospectively evaluate 25 individuals with severe behavioral health disabilities who completed a 1-year follow-up period after discharge from the program. Results indicated that following the program these individuals lived for significantly longer periods in the community in more independent settings and functioned at higher levels than in the 6 years prior to participation in the program.

In a study on obsessive compulsive disorder (OCD), Steward et al. identified consecutive intensive residential treatment (IRT) subjects were ascertained over a 12 month period (female n =26, male n =35). Psychometric measures were completed at admission and discharge from the McLean/MGH OCD Institute IRT, including the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), Beck Depression Inventory (BDI) and the Work and Social Adjustment Scale (WSA) (n = 61). These measures were repeated at 1 (n = 57), 3 (n = 42) and 6 months (n = 36) following discharge. This study was IRB approved. Obsessive compulsive disorder mean severity did not significantly worsen from discharge to the 1 (17.4, SD 6.5), 3 (16.5, SD 7.4) or 6 month (16.2, SD 7.3) follow-up ($p > 0.25$). Furthermore, the significant improvement from admission was maintained at each of the 1 (17.4, SD 6.5), 3 (16.5, SD 7.4) and 6 month (16.2, SD 7.3) follow-up time points ($p < .001$). Relapsers were significantly more likely to be living alone following discharge ($p = 0.01$), and were less likely to have comorbid illnesses ($p = 0.02$). There were no significant differences found between study dropouts and completers with regards to YBOCS scores ($p > 0.47$). In the first OCD IRT long-term follow-up study to date, findings have indicated that mean treatment gains were maintained at 1, 3, and 6 months post-discharge. This finding is important as it suggests that improvements of OCD severity were subsequently retained in home and work environments. Improvement of depression severity from admission was also maintained.

Observational studies have described RTC residents as well as resident and program characteristics associated with better outcomes. In 1 large observational study, RTC residents had high rates of unemployment, social isolation, and prior treatment. About 40% had a concomitant behavioral health illness. In another study of approximately 2,800 residents from a nationally representative sample of 88 RTCs, greater motivation for treatment, social and personal resources, and prior involvement with self-help groups were associated with better outcomes. More severe substance abuse and co-morbid behavioral health problems were associated with worse outcomes. A third study found that RTCs with a more structured approach to treatment had better retention rates and outcomes than programs with a more generic approach.

With regard to the issue of proximity of the residential treatment in reasonable proximity to a member's community or residence and support system, SAMSHA and other organizations have noted that outcomes are improved when residential care is provided in close proximity to the patient's home. In the Guidelines published in 2009 outlining the guiding principles and core elements of recovery oriented care SAMSHA in combination with treatment, recovery support services can enable individuals to build a life that supports recovery as they work to control symptoms though traditional treatments or peer-

support groups. These types of services support the goals of community integration and social inclusion for people with mental and/or substance use disorders and their families. SAMHSA also encourages the use of peer support services, or services designed and delivered by people who have experienced a mental and/or substance use disorder and are in recovery.

Applicable Coding

Revenue Codes

1001 Residential treatment, psychiatric (mental health)

1002 Residential treatment, chemical dependency (substance use disorders

CPT Codes

No applicable codes

HCPCS Codes

H0010 Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)

H0011 Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)

H0012 Alcohol and/or drug services; subacute detoxification (residential addiction program outpatient)

H0013 Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)

H0017 Behavioral health; residential (hospital residential treatment program), without room and board, per diem

H0018 Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem

H0019 Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem

H2013 Psychiatric health facility service, per diem

H2036 Alcohol and/or other drug treatment program, per diem

T2048 Behavioral health; long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem

References:

1. Hartwell, K., Brady, K. (2010). Clinical management of substance dependence across the continuum of care. UpToDate. Updated: February 12. Date Accessed: January 30, 2011. Available: http://www.uptodate.com/online/content/topic.do?topicKey=substan/11754&selectedTitle=1%7E150&source=search_result#H4

2. Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, American Academy of Child and Adolescent Psychiatry, June 2010.
3. Psychiatric Residential Treatment Facilities (PRTF) Clarification, Center for Medicaid and State Operations/Survey and Certification Group, Ref: S&C-07-15, February 16, 2007.
4. Sheedy C. K., and Whitter M., Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.
5. Stewart SE. (2009). Long-term outcome following Intensive Residential Treatment of Obsessive-Compulsive Disorder. J Psychiatr Res. Sept 1; 43(13): 1118-23.
6. Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Treatments and Services October 19, 2015 Available: https://www.samhsa.gov/treatment
7. Utah Admin Rule R501-19 - Residential Treatment Program
8. Vandevooren, J., (2007). Outcomes in community-based residential treatment and rehabilitation for individuals with psychiatric disabilities: a retrospective study. Psychiatr Rehabil J. January 1; 30(3): 215-7.

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