Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Intensive Outpatient Program

<table>
<thead>
<tr>
<th>MNG #: 029</th>
<th>SCO</th>
<th>One Care</th>
<th>Prior Authorization Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical:</td>
<td>☒</td>
<td></td>
<td>Yes ☒ No</td>
</tr>
<tr>
<td>Operational:</td>
<td>☐</td>
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<tr>
<td>Medicare Benefit:</td>
<td>Yes ☒ No</td>
<td>Approval Date: 9/12/2019; Effective Date: 4/25/2020</td>
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<tr>
<td>Last Revised Date:</td>
<td>5/4/2020</td>
<td>Next Annual Review Date: 9/12/2020; 5/4/2021</td>
<td>Retire Date:</td>
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OVERVIEW:
The Intensive Outpatient Psychiatric program (IOP) is on the continuum of care made available for behavioral health needs. IOP is a program like a partial hospital program. The IOP provides intensive support in a therapeutic milieu during daytime as well as evening hours. The goal of the IOP is to prevent inpatient psychiatric hospitalization or to assist with the transition from an inpatient level of care. Treatment is available 5 to 7 days per week, typically, in 3 to 3.5-hour blocks, which includes evenings. On the continuum of psychiatric care, it is less restrictive than partial hospitalization, but more restrictive than traditional outpatient psychiatric care provided by a psychiatrist or other behavioral health clinician. IOP may be provided in a hospital or community based outpatient setting. The treatment plan is developed with the member and the multidisciplinary team at the facility. Treatment includes but is not limited to:

- Individual/group Therapy
- Health Education
- Symptom Management
- Psychosocial Therapy

Intensive Outpatient Program provide between 9-11 hours per week of therapy. The number of days attended per week may vary based on the individual’s acuity. General length of stay ranges from 1-3 weeks

DECISION GUIDELINES:
Clinical Eligibility:
These services are for individuals who may be experiencing an increase in symptoms that do not require an inpatient level of care, but present other risks (e.g., suicidal/homicidal ideation with no intent, or psychiatric destabilization that cannot be treated or supported in a less intensive setting).

- Member is experiencing symptoms that are disrupting his/her daily functioning due to a psychiatric illness.
- Member has adequate capacity to engage in treatment and benefit from services.
- Member is not in danger of hurting himself/herself or others that would require a 24-hour inpatient setting.
- Member’s symptoms are severe enough that he/she cannot be treated in a less intensive setting.
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- Member has a supportive community setting that is available when not engaged in program.
- Member is committed to treatment program and can attend program consistently.
- Member requires a more structured daily program and has access to a clinical team daily.
- Member may be at risk for inpatient level of care if not engaged in Intensive Outpatient Program (IOP).
- Services must be provided in accordance with the member’s goals as stated in the care plan.

Determination of Medical Necessity:
- These services may be utilized as a transition from an acute inpatient level of care, when appropriate, as well as diversionary.
- Services may be used for individuals with physical, mental, and/or cognitive impairments who are unable to safely or effectively perform an activity and for whom having such services will support his/her improved health status and their ability to maintain integrated living in the community.

LIMITATIONS/EXCLUSIONS:
CCA will collaborate with Interdisciplinary Care Team (ICT) and facility when considering a Discharge Plan

KEY CARE PLANNING CONSIDERATIONS:
- CCA may share information as appropriate to help providers/facility understand the member’s history, current treatment, and treatment needs.
- The member must actively participate in the treatment plan.
- The treatment plan is developed with appropriate and individualized goals and interventions.
- Consideration is made to determine the appropriate level of behavioral health care for member.

AUTHORIZATION:
The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not signify whether the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply. This Medical Necessity Guideline is subject to all applicable laws and regulations, Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider’s agreement with the Plan (including complying with Plan’s Provider Manual specifications).
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S9480 Intensive outpatient psychiatric services, per Diem

RELATED REFERENCES:
This MNG is not a rigid rule.

Center for Medicare Services; Medicare Benefit Manual: Chapter 2, 5, and 15.

1. CMS Manual pub 100-02 1861
3. Association for Ambulatory Behavioral Health 2010 [http://aabh.org/content/fast-facts-php](http://aabh.org/content/fast-facts-php)

ATTACHMENTS:

| EXHIBIT A: |   |
| EXHIBIT B: |   |