Introduction:

Comprehensive Behavioral Care (CompCare) welcomes you as a provider in our network and is supplying you with this manual to use as a step-by-step guide in the process of delivering care to our members, our goals and our requirements. The Provider Manual is designed to inform our network providers about CompCare’s policies, procedures, and provider requirements, as well as to answer everyday provider questions and concerns. CompCare values its on-going partnership with its network providers. Communication is essential to making a partnership work. You will be notified as any revisions or updates are added to the manual, which is always available on the CompCare website at www.compcare.com.

This manual details the procedures developed by CompCare to assure that all members/consumers receive the most appropriate services available in the least restrictive environment possible. The manual addresses the following issues:

- Contracting
- Credentialing/Recredentialing
- Access to Care
- Covered Services
- Treatment Authorizations
- Utilization Management
- Claims Processing
- Quality Improvement
- Customer/Member Services
- Prevention

CompCare hopes you find the manual to be a valuable tool that informs you, provides answers to common questions, and assists you in serving our members. Hopefully this will not become yet another provider manual placed on the bookshelf to collect dust, but rather, a “quick-answer” reference tool to assist you.

We look forward to our continued working relationship with you and welcome your comments and suggestions regarding the manual and any other way that we can better assist you in providing quality care to our members/consumers.
Behavioral Health Services for Florida Medicaid Members—Covered Services, Limitations and Exclusions:

These services include treatment for psychiatric and emotional disorders. CompCare will assign members and grant authorizations to behavioral health care providers based on several factors, including member choice, when feasible, provider qualification, provider proximity to the member, and the level or type of services that best meets the members clinical presentation. We will grant authorizations and continue to monitor the member’s treatment through the concurrent review processes that are outlined in the authorization section of this handbook. Our clinical staff can be reach 24 hours a day, 7 days a week, via 800-435-5348, to provide authorizations for services.

Behavioral Health services are provided in a hospital, or in an outpatient clinic or office. All services must be provided by licensed mental health professionals, psychologists, psychiatrists, and specially trained nurses who are skilled in providing behavioral health care. Specific provider qualifications for each service are specified in Behavioral Community Mental Health Handbook (an HMO may exceed the education and training requirement, but must otherwise follow the handbooks specifications).

Covered Services include:

The following is a listing of covered services: (see the attached health plan specific benefit grid for details regarding benefit limitations.

- Inpatient Hospital Services (Mental Health Diagnosis)
- Outpatient Hospital Services (Mental Health Diagnosis)
- Physician Services (Mental Health Diagnosis)
  - Community Mental Health Services Treatment Plan Development and Modification
  - Assessment Services
  - Medical and Psychiatric Services
  - Behavioral Health Therapy Services
  - Community Support and Rehabilitation Services
  - Therapeutic Behavioral On-Site Services for Children and Adolescents (TBOS)
  - Services for Children Ages 0-5 Years (Behavioral Health Day Services and TBOS)
  - Crisis Intervention Mental Health Services and Post-Stabilization Care Services
  - Substance Abuse Services by Referral (available through fee-for-services only)
- Mental Health Targeted Case Management
• Intensive Case Management

Authorization for services is based on medical necessity (see Medical Necessity section for detailed information).

Prior Authorization Requirements:

While prior authorization is required for all covered services with exception of emergency services (refer to emergency services section for additional details), CompCare is committed to making access to care as convenient and timely as possible. The process begins with a call from either a provider, member, PCP, CMHC, etc. to our twenty-four hour member/provider service line at the Tampa office. A Care Advocate will determine if the member has an emergent situation. If so, the caller will immediately be transferred to a clinical Care Manager who will arrange disposition and referral.

If the call is routine, the member/consumer’s eligibility and benefits will be verified. Calls for routine outpatient care will be referred to a network provider based on specialty, member/consumer preference, and geographic location. A licensed Care Manager who will guide the member/consumer to the most appropriate care and will review all other requests for treatment.

Prior authorization is obtained by contacting CompCare at 877-224-0972 or routine, non-emergency services our staff is available Monday through Friday 8:30 a.m. to 5:30 p.m. We are available 24/7 for emergency services authorization. At the time of the call, you will need to provide us with the following information:

• Member’s identification number
• Member’s First and Last Name
• We may ask you to verify the member’s address and date of birth
• We will need the presenting problems
  o We will inquire if the member is currently suicidal or homicidal
• Any prior mental health or substance abuse treatment
• Other insurance. If so, we need the other insurance information.
• When is the date of appointment scheduled
• Who will be treating the member
• We will verify that treating provider is a network provider.

Upon review of this information, our Care Advocate staff will grant authorization for initial services. The number of units authorized initially will depend on the level of service being requested as well as any special contractual arrangements that have been made with the provider. These authorizations will be granted over a 120 day timeframe with the exception of Medication
Management that will be granted for up to 12 months if the member is on maintenance medication. Services such as T-Bos and Targeted Case Management do not require any prior authorization.

If you have been identified as a Quick Net Provider (please refer to your contract for details), who are generally community based group provider organization, no authorization is required for outpatient services.

Upon completion of the initial authorized visits, we require our providers to submit updated clinical information via our Outpatient Treatment Review Form (OTR) that can be submitted via any one of the following options, on-line through our web-site at www.compcare.com, certified e-mail, fax or U.S. Mail. You may receive payment for the submission of the OTR form via service code H0031-TS (it does not require prior authorization)

- On-line through our web-site does **not** require an identification number or password and is available to you 24 hours per day, 7 days per week.
- Contact our VP of Information Systems to set-up a Certified e-mail account. He may be reached @ 1-813-288-4808
- Fax number – 1-877-436-3604
- Mailing Address: 3405 W. Dr. Martin Luther King, Jr., Tampa, FL 33607

Additional authorized visits will be based on medical necessity and the number of units authorized various depending on level of care the member is receiving.

It should be noted that higher levels of care (i.e. inpatient, partial hospitalization, etc) require a telephonic review with our Care Management Staff. These telephonic reviews are scheduled in advance with the Utilization Review staff at the facility. In addition, special provisions are in place for those members with chronic conditions, as Florida Statutes require a standing order.

**Excluded Services include:**

The following services are not covered:

1. Specialized Therapeutic Foster Care
2. Therapeutic Group Care Services
3. Behavioral Health Overlay Services
4. Community Substance Abuse Services
5. Residential Care
6. Sub-acute Inpatient Psychiatric Program (SIPP) Services
7. Clubhouse Services
8. Comprehensive Behavioral Assessment, and
9. Florida Assertive Community Treatment Services (FACT)
Long term care institutional services of a nursing home, an institution for persons with developmental disabilities, specialized therapeutic foster care, children’s residential treatment services, or state hospital services are not covered.

For members requiring those services, CompCare shall consult the Medicaid Field Office and/or the Districts' DCF ADM offices to identify appropriate methods of assessment and referral. CompCare is responsible for transition and referral to appropriate service providers. Members receiving those services shall be disenrolled from the plan. CompCare will notify and refer to the Health Plan regarding disenrollment processes. If CompCare determines the need for behavioral health services are not covered under the contract, CompCare shall refer the member to the appropriate service provider. CompCare may request the assistance of the Medicaid Field Office or the DCF Districts’ ADM offices for referral to the appropriate service setting.

Providing appropriate referral of the enrollee for non-covered services to the appropriate service setting, and requesting referral assistance, as needed, from the Medicaid Field Office. We will utilize the Florida Supplement to the American Society of Addictions Medicine Patient Placement Criteria for coordination and treatment of substance-related disorders with substance abuse providers. Coordination of care with community-based substance abuse agencies shall be included in protocols developed for continuity of care practices for enrollees with dual diagnoses of mental illnesses and substance abuse or dependency.

**Description and Requirements of Covered Services:**

**Inpatient Hospital Services:**

Inpatient Hospital services are medically necessary mental health care services provided in a hospital setting (see Section V.B.8, Covered Services, Hospital Services – Inpatient, in this Contract). Services may be provided in a general Hospital psychiatric unit or in a specialty Hospital. The inpatient care and treatment services that an Enrollee receives must be under the direction of a licensed physician with the appropriate Medicaid specialty requirements.

- A hospital’s per diem (daily rate) for inpatient mental health hospital care and treatment covers all services and items furnished during a 24-hour period. The facilities, supplies, appliances, and equipment furnished by the hospital during the inpatient stay are included in the per diem as well as the related nursing, social, and other services furnished by the hospital during the inpatient stay.
- For all Adult Enrollees, CompCare shall be responsible for the provisions of up to 45 days annually combined with medical and behavioral health services.
• For all Child/Adolescent Enrollees, CompCare shall be responsible for the provision of up to 365 days of mental health related Hospital inpatient care for each year.

• For all Enrollees, CompCare shall pay for inpatient mental health related Hospital days determined Medically Necessary by CompCare’s medical director or designee, up to the maximum number of days required under the Contract.

• If an Enrollee is admitted to a Hospital for a non-psychiatric diagnosis and during the same hospitalization transfers to a psychiatric unit or the treatment of a psychiatric diagnosis, CompCare is at risk for the Medically Necessary mental health treatment inpatient days up to the maximum number of days required under the Contract.

• CompCare shall be responsible to cover the cost of all Enrollees’ Medically Necessary stays resulting from a mental health emergency, until such time as Enrollees can be safely transported to a designated facility.

• Crisis Stabilization Units may be used as a downward substitution for inpatient psychiatric hospital care when determined medically appropriate. These bed days are included toward the 45-day coverage count discussed above in A.1. They are calculated on a two for one basis. Two CSU days count toward one inpatient day. Beds funded by the Department of Children and Families, Substance Abuse and Mental Health (SAMH) cannot be used for Enrollees if there are non-funded clients in need of the beds. If CSU beds are at capacity, and some of the beds are occupied by Enrollees, and a non-funded client presents in need of services, the Enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, CompCare must demonstrate adequate capacity for inpatient hospital care in anticipation of such transfers.

Outpatient Hospital Services:

Outpatient Hospital services are Medically Necessary mental health care services provided in a hospital setting. The outpatient care and treatment services that an Enrollee receives must be under the direction of a licensed physician with the appropriate specialty.

Physician Services:

Physician services are those services rendered by a licensed physician who possesses the appropriate Medicaid specialty requirements when applicable. A psychiatrist must be certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.
Physician services include specialty consultations for evaluations. A physician consultation shall include an examination and evaluation of the Enrollee with information from family member(s) or significant others as appropriate. The consultation shall include written documentation on an exchange of information with the attending Provider. The components of the evaluation and management procedure code and diagnosis code must be documented in the Enrollee's medical record. A Hospital visit to an Enrollee in an acute care Hospital for a mental health diagnosis must be documented with a mental health procedure code and mental health diagnosis code. All procedures with a minimum time requirement shall be documented in the medical record to show the time spent providing the service to the Enrollee. The Health Plan must be responsive to requests for consultations made by the PCP.

Physicians are required to coordinate Medically Necessary mental health care with the PCP and other Providers involved with the care of the Enrollee. CompCare will have a set of protocols that indicate when such coordination will be required.

Community Mental Health Services – Covered Services:

Community mental health services include mental health services that are provided for the maximum reduction of the Enrollee’s mental health disability and restoration to the best possible functional level. Community mental health services can reasonably be expected to improve the Enrollee’s condition or prevent further regression so that the services will no longer be needed. The health plan must provide services that are medically necessary and are rendered or recommended by a physician, psychiatrist, or licensed mental health professional and included in an individualized treatment plan. Medically Necessary community mental health services must be provided to Enrollees of all ages from very young children through the geriatric population. Provision of services very early may reduce the provision of expensive services later, and the health plan is encouraged to use creativity, flexibility, and outreach to provide mental health services to its enrollees. Services should be age appropriate and sensitive to the developmental level of the enrollee.

The services provided must meet the intent of the services covered in the Florida Medicaid Community Mental Health Services Coverage and Limitations Handbook. Although the Health Plan can provide flexible services, the service limits and medical necessity criteria cannot be more restrictive than those in Medicaid policy as stated in Medicaid handbooks and this Contract. Additionally, the Health Plan may have available additional services, but must have the core services available as outlined and discussed below.
CompCare will establish “Medical Necessity” criteria (see page 17), including admission criteria, continuing stay criteria, and discharge criteria for all mandatory services.

Criteria must be specific to enrollee ages and diagnoses and must account for orders for involuntary outpatient placement pursuant to 394.4655, F.S. These criteria must be submitted for review by the Agency and approval.

The following describes basic categories of mental health care services considered core services. The frequency, duration, and content of the services should be consistent with the age, developmental level and level of functioning of the enrollee. CompCare will develop clinical care criteria appropriate for each service to be provided. CompCare will consult the most recent the Community Behavioral Health Services Coverage and Limitations Handbook published by the Agency.

Treatment Plan Development and Modification

Treatment planning includes working with the Enrollee, their natural support system, and all involved treating Providers to develop an individualized plan for addressing identified clinical needs. A Behavioral Health Care Provider must complete a face-to-face interview with the Enrollee during the development of the plan.

The Individualized Treatment Plan shall:

• be recovery oriented and promote resiliency;
• be enrollee directed;
• Accurately reflect the presenting problems of the enrollee;
• be based on the strengths of the enrollee, family, and other natural support systems;
• provide outcome oriented objectives for the enrollee;
• include an outcome oriented schedule of services that will be provided to meet the enrollee’s needs;
• include the coordination of services not covered by the plan such as school based services, vocational rehabilitation, housing supports, Medicaid fee for service substance abuse treatment, and physical health care.

Individualized Treatment Plan reviews shall be conducted at six month intervals to assure that the services being provided are effective and remain appropriate for addressing individual needs. Additionally, a review is expected whenever clinically significant events occur. The provider is expected to use the Individualized Treatment Plan review process in the utilization management of medically necessary services.
For further guidance see the most recent Community Behavioral Health Services and Coverage Handbook.

Assessment Services:
These services include psychological testing (standardized tests) and evaluations that assess the enrollee’s functioning in all areas. All evaluations must be appropriate to the age, developmental level and functioning of the enrollee. All evaluations must include a clinical summary that integrates all the information gathered and identifies enrollee’s needs. The evaluation should prioritize the clinical needs, evaluate the effectiveness of any prior treatment, and include recommendations for interventions and services to be provided.

Evaluation or assessment services, when determined medically necessary, must include assessment of mental status, functional capacity, strengths, and service needs by trained mental health staff. Also included in this category is the administration of the functional assessments that are required by the Agency, DCF, the EQRO, or academic research center.

Prior to receiving any community mental health services, children ages 0-5 must have a current assessment (within one year) of presenting symptoms and behaviors; developmental and medical history; family psychosocial and medical history; assessment of family functioning; a clinical interview with the primary caretaker and an observation of the child’s interaction with the caretaker; and an observation of the child’s language, cognitive, sensory, motor, self care, and social functioning.

Medical and Psychiatric Services:

These services include Medically Necessary interventions that require the skills and expertise of a psychiatrist, psychiatric ARNP, or physician.

Medical psychiatric interventions include the prescribing and management of medications, monitoring of side effects associated with prescribed medications, individual or group medical psychotherapy, psychiatric evaluation, psychiatric review of treatment records for diagnostic purposes, and psychiatric consultation with an enrollee’s family or significant others, primary care providers, and other treatment providers.

Psychiatric or physician services must be available at sites where substantial amounts of community mental health services are provided.

Behavioral Health Therapy Services:
These services include individual and family therapy, group therapy, and behavioral health day services. These services include psychotherapy or supportive counseling focused on assisting enrollees with the problems or symptoms identified in an assessment. The focus should be on identifying and utilizing the strengths of the enrollee, family, and other natural support systems. Therapy services should be geared to the individual needs of the enrollee and should be sensitive to the age, developmental level, and functional level of the enrollee.

Family or marital therapy is also included in this category. Examples of interventions include those that focus on resolution of a life crisis or an adjustment reaction to an external stressor or developmental challenge.

Behavioral Day Services are designed to enable individuals to function successfully in the community in the least restrictive environment and to restore or enhance ability for social and prevocational life management services. The primary functions of behavioral health day services are stabilization of the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care, to provide transitional treatment after an acute episode, or to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

Community Support and Rehabilitative Services:

These services include: Psychosocial Rehabilitation Services and Clubhouse services. Clubhouse services are excluded from the health plan’s covered services. Psychosocial rehabilitation services may be provided in a facility, home, or community setting. These services assist enrollees in functioning within the limits of a disability or disabilities resulting from a mental illness. Services focus on restoration of a previous level of functioning or improving the level of functioning. Services must be individualized and directly related to goals of improving function within a major life domain.

The coverage must include a range of social, educational, vocational, behavioral, and cognitive interventions to improve enrollees’ potential for social relationships, occupational/educational achievement and living skills development. Skills training development is also included in this category and includes activities aimed toward restoration of enrollees’ skills/abilities that are essential for managing their illness, actively participating in treatment, and conducting the requirements of daily independent living. Providers must offer the services in a setting best suited for desired outcome, i.e., home or community-based settings.

Psychosocial Rehabilitative Services may also be provided to assist individuals in finding or maintain appropriate housing arrangements or to maintain
employment. Interventions should focus on the restoration of skills/abilities that are adversely affected by the mental health illness and supports required to manage the individual’s housing or employment needs. The provider must be knowledgeable about the local TANF initiative and is responsible for medically necessary mental health services that will assist the individual in finding and maintaining employment.

Therapeutic Behavioral On-Site Services for Children and Adolescents (TBOS):

Therapeutic Behavioral On-Site Services are community services and natural supports for children with serious emotional disturbances. Clinical services include the provision of a professional level therapeutic service that may include the teaching of problem solving skills, behavioral strategies, normalization activities and other treatment modalities that are determined to be medically necessary. These services should be designed to maximize strengths and reduce behavior problems or functional deficits stemming from the existence of a mental health disorder. Social services include interventions designed for the restoration, modification and maintenance of social, personal adjustment and basic living skills.

These services are intended to maintain the child in the home and to prevent reliance upon a more intensive, restrictive, and costly mental health placement. They are also focused on helping the child possess the physical, emotional, an intellectual skills to live, learn and work in their own communities. Coverage must include the provision of these services outside of the traditional office setting. The services must be provided where they are needed, in the home, school, childcare centers or other community sites.

Services for Children Ages 0-5 Years:

Services to these children include behavioral health day services and Therapeutic Behavioral On-Site Services for Children Ages 0 through 5 years.

Prior to receiving these services, the children in this age group must meet the criteria as stated in the Medicaid Community Behavioral Health Service Coverage and Limitations Handbook.

Crisis Intervention Mental Health Services and Post-Stabilization Care Services:

Crisis intervention services include intervention activities of less than 24-hour duration (within a 24-hour period) designed to stabilize an individual in a Psychiatric emergency.

Post-stabilization care services include any of the mandatory services that a treating physician view as medically necessary, that are provided after an enrollee is stabilized from an emergency mental health condition in order to
maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee’s condition.

Mental Health Targeted Case Management:

The Health Plan must provide targeted Case Management services to children/Adolescents with serious emotional disturbances and adults with a severe mental illness as defined below. CompCare will meet the intent of the services as outlined below and in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook. CompCare will set criteria and clinical guidelines for Case Management services. Service limits and criteria developed cannot be more restrictive than those in Medicaid policy and as stated below.

At a minimum, case management services are to incorporate the principles of a strengths-based approach. Strengths-based case management services are an alternative service modality for working with individuals and families. This method stresses building on the strengths of individuals that can be used to resolve current problems and issues, counter more traditional approaches that focus almost exclusively on individuals’ deficits or needs.

Target Populations:

- CompCare will have Case Management services available to Children/Adolescents who have a serious emotional disturbance as defined as: a Child/Adolescent with a defined mental disorder; a level of functioning which requires two or more coordinated mental health services to be able to live in the community; and be at imminent risk of out of home mental health treatment placement.

- CompCare must have case management services available for adults who:
  - Have been denied admission to a long-term mental health institution or residential treatment facility; or
  - Have been discharged from a long-term mental health institution or residential treatment facility.
  - Require numerous services from different providers and also require advocacy and coordination to implement or access services;
  - Would be unable to access or maintain consistent care within the service delivery system without case management services;
  - Do not possess the strengths, skills, or support system to allow them to access or coordinate services; CompCare does not need to seek
approval from the Department of Children and Families, 
District Substance Abuse and Mental Health (SAMH) Office for 
individual eligibility or mental health targeted case management 
agency 
or individual provider certification. The staffing requirements for case management services are listed below.

- Mental health targeted Case Management services shall be available to all Enrollees within the principles and guidelines described as follows:
  
  - Enrollees, who require numerous services from different providers and also require advocacy and coordination to implement or access services are appropriate for Case Management services;
  - Enrollees who would be unable to access or maintain consistent care within the service delivery system without Case Management services are appropriate for the service;
  - Enrollees who do not possess the strengths, skills, or support system to allow them to access or coordinate services are appropriate for Case Management services;
  - Enrollees without the skills or knowledge necessary to access services may benefit from Case Management. Case Management provides support in gaining skills and knowledge needed to access services and enhances the Enrollee’s level of independence.
  - CompCare will not be required to seek approval from the DCF, District Substance Abuse and Mental Health Program Office for client eligibility or mental health targeted Case Management agency or individual provider certification.

Required Mental Health Targeted Case Management Services:

Mental Health Targeted Case Management services include working with the Enrollee and the Enrollee’s natural support system to develop and promote a needs assessment-based service plan. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used should identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the enrollee, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with Providers and the Enrollee to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of the services provided. A strengths-based approach to providing services is consistent with the values of individuality and uniqueness and promotes participant self-direction and
choice. The planning process is vital to achieving desired outcomes for the individual. The person must have a sense of ownership about his/her goals, and the goals must have true meaning and vitality for him/her.

When targeted case management recipients enrolled in the health plan are hospitalized in an acute care setting or held in a county jail or juvenile detention facility, CompCare will maintain contact with the individual and shall participate actively in the discharge planning processes.

Case managers are also responsible for coordination and collaboration with the parents or guardians of Children/Adolescents who receive mental health targeted Case Management services. CompCare will make reasonable efforts to assure that case managers include the parents or guardians of Enrollees in the process of providing targeted Case Management services. Integration of the parent’s input and involvement with the case manager and other Providers shall be reflected in Medical Record documentation and monitored through the Health Plan’s quality of care monitoring activities. Involvement with the child’s school and/or childcare center must also be a component of case management with children.

Additional Requirements for Targeted Case Management:

CompCare have a Case Management program, including clinical guidelines and protocol that addresses the issues below:

- Caseloads must be set to achieve the desired results. Size limitations must clearly state the ratio of enrollees to each individual case manager. The limits shall be specified for children and adults, with a description of the clinical rationale for determining each limitation. If the health plan permits “mixed” caseloads, i.e., children and adults, a separate limitation is expected along with the rationale for the determination. Ratios must be no greater than the requirements set forth in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.
- A system shall be in place to manage caseloads when positions become vacant.
- The modality of service provision, and the location that services will be provided, shall be described.
- Case Management protocol and clinical practice guidelines, which outline the expected frequency, duration and intensity of the service, shall be available.
- Clinical guidelines shall address issues related to recovery and self-care, including services that will assist Enrollees in gaining independence from the mental health and Case Management system.
The Case Management program shall have services available based on the individual needs of the Enrollees receiving the service. The service should reflect a flexible system that allows movement within a continuum of care that addresses the changing needs and abilities of Enrollees.

- Case management staff must have expertise and training necessary to competently and promptly assist enrollees in working with Social Security Administration or Disability Determination in maintaining benefits from SSI and SSDI. For clients who wish to work, case management staff must have the expertise and training necessary to assist enrollees to access Social Security Work Incentives including development of Plans for Achieving Self-Support (PASS).
- At a minimum, case management services are to incorporate the principles of a strengths-based approach. Strengths-based case management services are a preferred service modality for work with individuals and families. This method stresses building on the strengths of individuals and families that can be used to resolve current problems and issues. This approach counters more traditional approaches that focus almost exclusively on individuals’ deficits or needs. Service limits and criteria developed cannot be more restrictive than those in Medicaid policy.

Intensive Case Management:

Intensive Case Management is intended to provide intensive team Case Management to highly recidivistic adults who have a severe and persistent mental illness. The service is intended to help Enrollees remain in the community and avoid institutional care. Clinical care criteria for this level of Case Management shall address the same elements required above, as well as expanded elements related to access and twenty-four (24) hour coverage as described below. Additionally, the intensive Case Management team composition shall be expanded to include members of the team selected specifically to assist with the special needs of this population. CompCare will include the team composition and how it will assist with special needs in the description of how this service will be provided.

CompCare will provide this service for all Enrollees for whom the service is determined to be Medically Necessary, to include enrollees who meet the following criteria:

- Has resided in a state mental health treatment facility for at least 6 months in the past 36 months;
- Resides in the community and has had two or more admissions to a state mental health treatment facility in the past 36 months;
- Resides in the community and has had three or more admissions to a crisis stabilization unit, short-term residential facility, inpatient psychiatric unit, or any combination of these facilities within the past 12 months; or
- Resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.
- Intensive Case Management provides services through the use of a team of case managers. The team can be expanded to include other specialists that are qualified to address identified needs of the Enrollees receiving intensive Case Management. This level of care for Case Management is the most intensive and serves Enrollees with the most severe and disabling mental conditions. Services are frequent and intense with a focus on assisting the Enrollee with attaining the skills and supports needed to gain independent living skills. Intensive Case Management services are provided primarily in the Enrollee’s residence and include community-based interventions.

CompCare will provide this service in the least restrictive setting with the goal of improving the Enrollee’s level of functioning, and providing ample opportunities for rehabilitation, recovery, and self-sufficiency. Intensive Case Management services shall be accessible twenty-four (24) hours per day, seven (7) days per week. CompCare will demonstrate adequate capacity to provide this service for the targeted population within the guidelines outlined.

Intensive Case Management teams shall provide the same coordination and services for Enrollees admitted to inpatient facilities, State mental Hospitals, and forensic or corrections facilities as those listed above for mental health targeted case management services.

**Emergency Services - participating Provider:**

CompCare will advise all Enrollees of the provisions governing Emergency Services and Care. CompCare will not deny claims for Emergency Services and Care received at a Hospital due to lack of parental consent. In addition, CompCare will not deny payment for treatment obtained when a representative of CompCare instructs the Enrollee to seek Emergency Services and Care.

The CompCare will not:
• Require Prior Authorization for an Enrollee to receive pre-Hospital transport or treatment or for Emergency Services and Care;
• Specify or imply that Emergency Services and Care are covered by the Health Plan only if secured within a certain period of time;
• Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
• Deny payment based on a failure by the Enrollee or the Hospital to notify the Health Plan before, or within a certain period of time after, Emergency Services and Care were given.

When an Enrollee presents himself/herself at a Hospital seeking Emergency Services and Care, the determination that an Emergency Medical Condition exists shall be made, for the purposes of treatment, by a physician of the Hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Hospital physician.

• The physician, or the appropriate personnel, shall indicate on the Enrollee's chart the results of all screenings, examinations and evaluations.
• CompCare shall compensate the provider for all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the Enrollee's condition is an Emergency Medical Condition.
• CompCare shall compensate for all Emergency Services and Care.
• If the provider determines that an Emergency Medical Condition does not exist, CompCare is not required to pay for services rendered subsequent to the provider’s determination.

If the provider determines that an Emergency Medical Condition exists, and the Enrollee notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is an Enrollee of the Health Plan, the hospital must make a reasonable attempt to notify the enrollee’s PCP, if known, or CompCare, if CompCare has previously requested in writing that said notification be made directly to CompCare, of the existence of the Emergency Medical Condition.

If the Hospital, or any of its affiliated providers, do not know the enrollee’s PCP, or have been unable to contact the PCP, the Hospital must:

• Notify CompCare as soon as possible before discharging the enrollee from the emergency care area; or
• Notify CompCare within twenty-four (24) hours or on the next Business Day after admission of the enrollee as an inpatient to the Hospital.

If the hospital is unable to notify CompCare, the Hospital must document its attempts to notify CompCare, or the circumstances that preclude the Hospital’s
attempts to notify CompCare. CompCare shall not deny payment for Emergency Services and Care based on a Hospital’s failure to comply with the notification requirements.

CompCare may transfer an enrollee, in accordance with State and federal law, to a participating hospital that has the service capability to treat the enrollee’s Emergency Medical Condition. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

Notwithstanding any other State law, a hospital may request and collect any insurance or financial information necessary to determine if the patient is an Enrollee of the health plan, in accordance with federal law, from an Enrollee, so long as Emergency Services and Care are not delayed in the process.

In accordance with 42 CFR 438.411 and 42 CFR 422.113(c), the CompCare will cover post stabilization care services without authorization, regardless of whether the Enrollee obtains a service within our outside CompCare’s network for the following situations:

- Post-Stabilization Care Services that were pre-approved by CompCare.
- Post Stabilization Care Services that were not pre-approved by CompCare because CompCare did not respond to the treating provider’s request for pre-approval within one (1) hour after the treating provider sent the request;
- The treating provider could not contact CompCare for pre-approval;
- Those Post-Stabilization Services that a treating physician viewed as Medically Necessary after the stabilizing an Emergency Medical Condition. These are non-emergency services; CompCare can choose not to cover if provided by a non-participating provider, except in those circumstances identified above.

CompCare will not deny claims for the provision of Emergency Services and Care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 days.

Reimbursement for services provided to an Enrollee under this Section by a non-participating provider shall be the lesser of:

- The non-participating provider's charges;
- The usual and customary provider charges for similar services in the community where the services were provided;
• The amount mutually agreed to by the Health Plan and the nonparticipating provider within sixty (60) Calendar Days after the non-participating provider submits a claim; or
• The Medicaid rate.

Notwithstanding the requirements set forth in this Section, CompCare will make payment on all claims for Emergency Services and Care by non-participating providers pursuant to the requirements set forth in section 641.3155, F.S.

Emergency Services – Non-participating Provider:

Emergency Services Behavioral Health Services provided by an out of area, nonparticipating provider should notify the Health Plan within twenty-four (24) hours (via 800-435-5348) of the Enrollee presenting for Emergency Behavioral Health Services. In cases in which the Enrollee has no identification, or is unable to verbally identify himself/herself when presenting for Behavioral Health Services, the out of area, nonparticipating provider shall notify the Health Plan within twenty-four (24) hours of learning the Enrollee's identity. The out of area, nonparticipating provider shall deliver to CompCare, the Medical Records that document that the identity of the Enrollee could not be ascertained at the time the Enrollee presented for Emergency Behavioral Health Services due to the Enrollee's condition.

If the out of area, non-participating provider fails to provide CompCare with an accounting of the Enrollee's presence and status within twenty-four (24) hours after the Enrollee presents for treatment and provides identification, the CompCare shall only approve claims for the time period required for treatment of the Enrollee's Emergency Behavioral Health Services, as documented by the Enrollee's Medical Record.

CompCare will review and approve or disapprove all out of plan Emergency Behavioral Health Service claims within the time frames specified for emergency claims payment in Florida Medicaid Contract Section V.D.3., Emergency Care Requirements.

CompCare shall submit to the Agency for review and final determination all denied Appeals from behavioral health care providers and out of plan, non-participating Behavioral Health Care Providers for denied Emergency Behavioral Health Service claims. The provider, whether a participating provider or not, must submit the denied Appeal to the Agency within ten (10) days after receiving notice of the Health Plan's final Appeal determination.

CompCare will evaluate and authorize or deny services for Enrollees presenting at nonparticipating receiving facilities (that are not Crisis Stabilization Units), within the Health Plan's service area, for involuntary examination within three (3) hours of being notified by phone by the receiving facility.
The receiving facility must notify CompCare within four (4) hours of the Enrollee presenting. If the Receiving Facility fails to notify CompCare of the Enrollee's presence and status within four (4) hours, CompCare shall pay only for the first four (4) hours of the Enrollee's treatment, subject to Medical Necessity.

If the receiving facility is a non-participating receiving facility and documents in the Medical Record that it is unable, after a good faith effort, to identify the Enrollee and, therefore, fails to notify the CompCare of the Enrollee's presence, CompCare will pay for medical stabilization lasting no more than three (3) days from the date the Enrollee presented at the receiving facility, as documented by the Enrollee's Medical Record and subject to Medical Necessity, unless there is irrefutable evidence in the Medical Record that a longer period was required to treat the Enrollee.

**Medical Necessity Criteria is as follows:**

The services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not to excess of the recipient’s needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.
- Services should not duplicate another provider’s services

It should be noted, the fact that a provider has prescribed, recommended or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

**Benefit Year:**

Service limits are per recipient, per state fiscal year (July 1, through June 30) are the following:
o For all Adult Enrollees 21 and over, CompCare shall be responsible for the provisions of inpatient behavioral health hospital care. The total number of inpatient hospital days, including medical and behavioral health inpatient days is limited to 45 days annually.

o For all Child/Adolescent Enrollees, CompCare shall be responsible for the provision of up to 365 days of mental health related Hospital inpatient care for each year.

o All other services are unlimited so long as medical necessity is demonstrated.

An exception is treatment plan development is reimbursed once per provider, per state fiscal year (July 1 through June 30).
Covered Diagnosis Codes:

Inpatient hospital care for psychiatric conditions (ICD9CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);

Outpatient hospital care for psychiatric conditions (ICD9CM codes 290 through 290.43, 293 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);

Psychiatric physician services (for psychiatric specialty codes 42, 43, 44 and ICD-9CM codes 290 through 290.43, 293 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);

Community mental health services (ICD9CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9); and for these procedure codes H0001, H0001HN; H0001H0, H0001TS; H0031; H0031 HO; H0031HN; H0031TS; H0032; H0032TS; H0046; H0047; H2000; H2000HO; H2000HP; H2010HO; H2010HE; H2010HF; H2010HQ; H2012; H2012HF; H2017; H2019; H2019HM; M2019HN; H2019HO; H2019HQ; H2019HR; H2030; T1007; T1007TS; T1015; T1015HE; T1015HF; T1023HE; or T1023HF.

Mental Health Targeted Case Management (Children: T1017HA; Adults: T1017);

Mental Health Intensive Targeted Case Management (Adults: T1017HK).

Claims for services rendered by providers will be paid only for the following diagnosis codes: 290 through 298.9, 300 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9. Diagnoses are found in the International Classification of Disease, 9th Revision, and Clinical Modifications (ICD-9-CM).

Claims must contain only the mental health or substance abuse diagnosis from the list above for each covered services available under the recipient’s health plan certificate of coverage.

Excluded Diagnosis Codes:

Reimburse for the treatment of autism pervasive developmental delay, non-emotional or non-behavioral based developmental disabilities or mental retardation. In addition, services are not considered to be medically reasonable within if the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that
have produced a cognitive deficient severe enough to prohibit benefit to the recipient. However, the primary behavioral health diagnosis will be covered with a secondary diagnosis of autism pervasive developmental delay.

Referral Process:

Member Access to Behavioral Health Services is a self-referral process. The member does not need to obtain a referral from their Primary Care Physician (PCP) in order to access behavioral health services. Members can simply contact our National Call Center to obtain a list of network providers to review and choose the provider that is best suited to their need. In addition, our National Call Center can advise members of providers that have specialty needs to ensure that all cultural and linguistic needs are met in addition to any other identified variables from the member.

In addition, the health plan will distribute (via U.S. Mail) a provider directory (including a listing of behavioral health providers) to all new enrollees. This directory will be updated at least annually. The provider directory is also available on the health plan’s web-site. The on-line provider directory is updated monthly.

Access to Care:

CompCare believes that timely and convenient access to treatment is a critical first step in ensuring that members/consumers receive safe and effective care. CompCare meets rigorous national standards related to access to care and services. We routinely evaluate the initial response time of our customer service representatives, timeliness of utilization management decisions, and access to care. We regularly monitor these systems to ensure that we meet established goals. Likewise, we believe that our providers should be equally committed to meeting or exceeding access standards for appointment availability.
ACCESS TO CARE FLOW CHART

Member/Consumer or Provider/Facility makes a call to Comprehensive Behavioral Care’s twenty-four (24)-hour pre-certification number

EMERGENCY

Member/consumer/facility immediately speaks with licensed Care Manager

Care Manager determines disposition plan and verifies benefits (if possible)

Care Manager authorizes medically necessary treatment based on Level of Care Guidelines and Clinical Care Protocols

Concurrent review by exception is conducted with a specified discharge plan

After care follow up or transition to a less-intensive level of care, as measured by the Level of Care Guidelines and Clinical Care Protocols

NON-EMERGENCY

Care Advocate verifies eligibility/benefits and obtains demographic information

Outpatient referral made to a group or provider for assessment and/or treatment

Provider contacts Care Manager to review assessment or continued treatment plan

Continue treatment?

YES

NO

Care Manager authorizes medically necessary treatment, based on outpatient care protocols and Level of Care Guidelines

Concurrent review by exception with specified brief treatment goals and treatment termination date

case closed

case closed

AFTER HOURS

5:30 pm-8:30 am

Emergency?

YES

NO

Member/Consumer or Provider/Facility instructed to call back during normal business hours

Emergency?

YES

Stabilized?

YES

NO

Care Manager authorizes emergency assessment or 23 hour stay for assessment completion, based on medical necessity, using the Level of Care Guidelines and Clinical Care Protocols

Transition to a less-intensive level of care, as measured by the Level of Care Guidelines and Clinical Care Protocols

Care Manager authorizes a medically necessary treatment, using the inpatient guidelines and Clinical Care Protocols, with concurrent review by exception and a specified treatment plan

“Easy Reference”
Access to Care Flowchart

page 24
Access Standards:

CompCare’s national standards for appointment scheduling are listed below. Some localities and/or clients require more stringent access standards. In these cases, the specific standards will be communicated with you via supplements to this manual.

Appointment Standards:

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>APPOINTMENT TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-Threatening Emergency – A member who a prudent layperson would</td>
<td>Life-threatening emergent cases should immediately be referred to a Care Manager who</td>
</tr>
<tr>
<td>judge to be at significant risk of inflicting serious injury or</td>
<td>will further assess and provide referral and direction to an appropriate level of care.</td>
</tr>
<tr>
<td>death upon self or other if not receiving immediate intervention.</td>
<td>Cases assessed as life-threatening should receive care within 2 hours of the initial</td>
</tr>
<tr>
<td></td>
<td>call. Emergency care for life-threatening situations should never be delayed due to</td>
</tr>
<tr>
<td></td>
<td>lack of a CompCare authorization.</td>
</tr>
<tr>
<td>Non-Life-Threatening Emergency – Members presenting with a clinical</td>
<td>Non-life-threatening emergent cases should immediately be referred to a Care Manager</td>
</tr>
<tr>
<td>situation that places them at significant risk of deteriorating into</td>
<td>who will further assess and provide referral and direction to an appropriate level of</td>
</tr>
<tr>
<td>a life-threatening emergency if not receiving prompt intervention.</td>
<td>care. Cases assessed as non-life threatening should receive care within 6 hours of the</td>
</tr>
<tr>
<td></td>
<td>initial call.</td>
</tr>
<tr>
<td>Urgent – Members presenting with significant psychiatric or substance</td>
<td>Urgent care should immediately be referred to a Care Manager who will further assess</td>
</tr>
<tr>
<td>abuse history, evidence of psychosis and/or in significant distress.</td>
<td>and provide referral and direction to an appropriate level of care. Care should occur</td>
</tr>
<tr>
<td></td>
<td>within (1) day.</td>
</tr>
<tr>
<td>Routine – Members seeking outpatient services who present no</td>
<td>Routine assessments should occur within (1) week of the request for service.</td>
</tr>
<tr>
<td>evidence of suicidal or homicidal ideation, psychosis, and/or</td>
<td></td>
</tr>
<tr>
<td>significant distress.</td>
<td></td>
</tr>
</tbody>
</table>

Inpatient, Rehabilitation, Day-Treatment Services (and Substance Abuse for Pregnant females):

CompCare makes every possible effort to ensure that emergent situations receive immediate response. The process is the same for emergency care 24 hours a day. Calling our member/provider service line 24 hours a day, 7 days a week can access care. Licensed staff is available for inbound calls and can make outbound calls 24/7. These calls can include requests for information about specific cases. Emergency care required for life threatening situations should never be delayed for the purpose of securing a prior authorization. Emergency
services can be reviewed retrospectively and always consider presenting symptoms.

Authorizations for services are based on medical necessity and Level of Care Criteria (see Level of Care Guidelines for additional information). The authorization is granted for a specific number of units for a specific level of care over a specific time period.

You will always be notified of denial decisions and will be given information on the appeal process—including the expedited appeal instructions verbally at the time of the denial and in writing mailed to you within three days of the verbal notification.

At the end of the authorization period, Concurrent Treatment Plan Information is discussed/reviewed with the assigned Care Manager prior to the end of the previous authorization. The first telephonic concurrent review is conducted within 24 hours of an admission. Subsequent reviews for continued stays are typically conducted every 2-3 days based on clinical need. When indicated, authorization for continuing care is given to the provider with the authorization number. All authorizations will be based on the CompCare Level of Care Guidelines. Providers will always be notified of denials. If you are treating a member in the hospital, concurrent decisions to continue authorizations for continued stay are communicated to you at the time of the Doc-to-Doc review or to the utilization management department at the facility. Prior to any denial of care, you will always be offered the opportunity to discuss the specific case with a CompCare Physician Advisor.

It is our policy that discharge planning begins at the time of admission. It is our requirement that a member have a scheduled after-care appointment with a network provider within 7 days of discharge. Our Care Management staff will then follow-up with the member to remind them of the after-care appointment.

**Outpatient Services:**

Upon review of the clinical information obtained by the member, provider or primary care physician’s office, the Care Advocate or Care Manager will grant an initial authorization for services at the appropriate level of care (see Level of Care Criteria for additional information). This authorization will be granted for a specific amount of services over a specific authorization period. Once the authorization period or the number of units is nearing completion, the treatment provider is required to submit a concurrent Outpatient Treatment Review form (see OTR Form at the end of this manual) to obtain additional services. For inpatient or more intensive services, the provider will conduct a telephonic review with our Care Management team.
Please note: There will be no reimbursement for the same procedure code performed twice in one day.

Primary Care Physicians Role:

A member’s PCP may act as a liaison on behalf of the member to access behavioral health services at a network provider. The PCPs office can contact our National Call Center to assist with the referral and authorization process. We can also accommodate any special requests to best match the provider to the member’s identified needs.

Coordination of care is paramount to a holistic approach to successfully servicing a member. CompCare has always made the commitment in its practices and within the confines of the provider contracts to ensure that if there are medical issues with the member, assistance with a referral back to the PCP ensures physical health needs are also being met.

Medical Record Standards:

Consistent, current and complete documentation in the treatment record is an essential component of quality patient care. The following are the guidelines to follow when reviewing medical records for information for the studies and record reviews.

- Identification and Legibility:

All pages contain member name or ID.

Each page of the medical record should have the member name or some member ID number.

Biographical (including date of birth, gender and legal guardianship (if applicable) and demographic data is clearly documented. Usually there is some sort of face sheet or information sheet that the member has filled out in the outpatient office or if inpatient the form is typed and used as a cover sheet to the record. Each record should include the patient’s address, employer or school, home and work telephone numbers including emergency contacts, marital status, appropriate consent forms and guardian information, if relevant.

- The clinician and his/her credentials are identified on each entry.

All entries in the treatment record are dated and include the responsible clinician’s name, and licensure. The professional degree and relevant identification number may also be included, if applicable. Name or first initial and last name should follow each entry in the record. First and last initials can be used if they are referenced and explained somewhere in the record.

- Advance Directives-Documentation that the Member was provided written information concerning advance directives and documentation as to whether or
not the member has executed an advance directive (as per Florida Statute 765.110 and Medicaid contract 20.13 Medical record requirements; Michigan Medicaid CHCP Contract requiring compliance with 42 C.F.R. 434.28 & Public Act 386 recognizing the Durable Power of Attorney for Healthcare (DPAHC); (Applies to Adults 18 and over).

The chart should contain documentation that the member was provided information on advance directives and documentation that the member was asked whether or not they had executed an Advance Directive. Not Applicable for members under 18 years of age.

- All entries are dated.
- The record is legible. The chart should be legible to someone other than the writer.
- Member Rights/Responsibilities are available. (Inpatient Only). Member rights and responsibilities are available in the facility or practitioner site for receipt, posted for viewing, and/or reviewed with the member for all levels of care.
- Are medical issues especially regarding obesity and pain being identified when signs and symptoms are being reported? All medical conditions are listed and updated when changes occur.

Under Axis III, as well as in the history and physical exam, all medical conditions are identified and any changes are noted in the progress notes. Also, medical issues regarding obesity and pain.

- Presenting problems, relevant psychological and social conditions are documented (including documentation of abuse and contact with DCF in FL, DSS in CT, FIA in MI, CPS or APS in TX).

Presenting problems, along with relevant psychological and social conditions affecting the member’s medical and psychiatric status and the results of the mental status exam, are documented. Contact with appropriate agency and the reporting to them of abuse and neglect situations are documented prominently.

- Special status situations are prominently noted, documented, and revised (Inpatient Only).

Special situations may include imminent risk of harm, suicidal ideation, elopement potential, etc. This may be addressed in the notes or in the treatment plan. Danger to self or others is acted upon by the practitioner/provider with the appropriate level of urgency.
Medications prescribed with dosages, and dates of initial prescription or refills are clearly documented.

Each record indicates what medications have been prescribed, the dosages of each and the dates of the initial prescription or refills. This includes only prescriptions that the patient is currently taking. This may be on a special medication sheet, physician’s order sheet, or in the progress notes.

Allergies and adverse reactions and/or lack of known allergies are clearly documented.

This must be addressed in the record and posted in a prominent place in the chart. If the patient is allergic to a medication we would expect this to be on the front of the chart (applies to MD’s and ARNP’s) and if the record is inpatient, we would expect it to be noted on the medication sheet. In addition, lack of known medication allergies and sensitivities is documented either on the outside of the chart (NKA, sticker) or in the notes. Credit for this indicator is only given if there is clear documentation.

Medical and psychiatric histories are documented.

This applies to both inpatient and outpatient records. The record needs to include a documented medical and psychiatric history, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.

Prenatal peri-natal events and a complete developmental history are documented (for child. & adol.).

This developmental history should include normal milestones and be addressed in both the inpatient and outpatient record. A complete developmental history includes physical and psychological, social, intellectual, and academic.

For members 12 and over, past and present use (or non-use) of cigarettes and alcohol as well as prescribed, over-the-counter, and illicit drugs are documented.

Documentation may be found in the medical and psychiatric evaluations or notes that the patient uses substances or denies use. For members under 12, only use N/A.

Appropriate Treatment Plan

A mental status exam is documented.
A Mental Status Exam includes the patient’s affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control.

- A DSM IV diagnosis is documented.

All five axes are identified in initial psychiatric history and evaluation. The record shows a minimum of symptoms to support the diagnosis.

- The treatment plan is consistent with diagnosis and has measurable goals and estimated time frames for attainment.

Supporting documentation should be found in the treatment plan and progress notes.

- The treatment interventions are consistent with treatment plan goals.

- Therapy and medications are appropriate for diagnosis.

- Informed consent for medication is documented.

The patient’s signature may be found on copies of medication education forms or noted in the Progress Notes.

- There is supporting documentation that the member understands and agrees with the treatment plan.

The member’s dated signature indicating participation in the development of the treatment plan and agreement with the plan should be found on the treatment plan form. If the member refuses to sign, this should also be documented.

- The progress notes describe member strengths and limitations in achieving treatment plan goals.

Evidence may also be found in the initial psychiatric evaluation.

- Members who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

For instance an agitated member may need to be secluded. At the outpatient level, a suicidal member may need to be transferred to an inpatient facility.

- The treatment record documents preventive services.
The treatment record documents preventive services as appropriate such as AA/NA, relapse prevention, case management services, job placement, stress management, wellness programs, housing, food banks, etc.

- The treatment record reflects continuity and coordination of care among behavioral health clinicians, consultants, ancillary providers, and health care institutions.

This refers to communication between behavioral health providers and practitioners. For example: the member may be seeing a therapist and an MD and we would expect communication between them. Release of information should be offered to the member to allow the exchange of information to appropriate practitioners. Another example includes lack of psychiatrist feedback documented in treatment records of non-psychiatrist behavioral health practitioners.

- The treatment record shows evidence of continuity and coordination of care between behavioral health practitioners and medical practitioners?

This refers to the exchange of information regarding medication, management of co-existing behavioral/medical disorders; i.e., obesity, pain, or exchange of information following a referral to behavioral health from medical.

- The treatment record documents the dates of follow-up appointments for continued treatment and/or discharge plans after hospitalization for follow-up treatment based upon appropriate level of care?

The treatment record documents dates of follow-up appointments or, as appropriate, discharge plan (OP appointment offered within 7 days following d/c from inpatient). Also need to see evidence of next outpatient appointment.

- The treatment record shows history of alcohol use/abuse?

The Treatment record shows evidence of history of alcohol abuse or alcohol use significant to impact daily functioning.

- The treatment record shows history of drug (other than alcohol) use/abuse?

The treatment record shows evidence of history of drug use (other than alcohol) significant to impact daily functioning.

- The treatment record shows current use/abuse of alcohol?

If Yes, please review questions 56-60. The treatment record shows evidence of current use/abuse of alcohol significant to impact daily function.
• The treatment record shows current use/abuse of drugs (other than alcohol)?

If Yes, please review questions 56-60. The treatment record shows evidence of current use/abuse of drugs significant to impact daily function.

• The PCP was notified of hospitalization/treatment/medication.

Release of information should be offered to the member to allow the exchange of information to appropriate practitioners. Credit is given if there is a signed release obtaining consent and is documented in the record. Patient may refuse to sign and if so there should be documentation that the patient refused. If patient claims no PCP or treating professional, no credit is given as provider should be proactive in obtaining a PCP for member unless member is a PPO member.

• The GAF score positively increased over a period of 3 months of treatment.

• CFARS/FARS has to be administered 6 months after the initial assessment or at discharge whichever comes first. This data is reported for all Medicaid recipients. FMHI guidelines must be followed.

• Referrals for additional services (including labs, emergency room visits, etc.)
Provider Services:

CompCare contracts with group practices, independent providers, agencies, facilities, and other behavioral health care resources to offer the most effective care possible to our members/consumers.

The CompCare Provider Services Department (Provider Services) is responsible for the development, maintenance, and coordination of a comprehensive network, clinically aligned with the overall needs of the member population. Provider Services is the liaison between our network providers and CompCare. Provider services:

- Introduces the credentialing and re-credentialing process to providers
- Introduces the contracting process to providers
- Assists providers in complying with credentialing and re-credentialing standards
- Interprets contract language and rates
- Clarifies policies and procedures
- Assists providers in making changes to their demographic profile
- Addresses any issues providers have regarding their credentialing status
- Addresses any issues providers have regarding their contract

Credentialing Process:

Written policies and procedures define the credentialing process. Selection decisions are based not only on the practitioner’s qualifications but also on the network and member needs. The Provider Selection Committee reviews practitioners/providers requesting inclusion in CompCare’s network. This committee also reviews all practitioners for re-credentialing based on NCQA requirements. Decisions are based on network needs, member complaints, peer review issues, and any site visits or record reviews. If you wish to join the network the provider selection form is located under the forms folder in the provider resources section of our website (www.compcare.com).

All members of the Credentialing Committee vote on decisions regarding credentialing and re-credentialing and are charged with ensuring that credentialing decisions are non-discriminatory and based on the applicants ability to meet member needs rather than race, ethnic/national identity, gender, age or sexual orientation. CompCare reviews practitioner applications and includes practitioners who meet certain demographic or specialty needs such as cultural needs of members.
Types of Practitioners Accepted in the Network:

We credential organizational providers, psychiatrists, addiction medicine specialists, psychologists, clinical social workers, psychiatric nurses and other independent behavioral health care practitioners who are at the master’s level or above and who are authorized by their licensing state to practice independently.

Credentialing Application:

The Credentialing Committee looks at your application information. Specifically we are required to obtain information about the following. Your signature on your application attests to the correctness of the information requested:

- Reasons for any inability to perform the essential functions of the position
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage
- Correctness and completeness of the application
- Additionally, our contracted CVO will verify the following:
  - Licensure; current and valid
  - Drug enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificates
  - Education and training
  - Board Certification when you state you are board certified
  - A five year work history
  - Malpractice history for the past five years
  - Medicare, Medicaid, NPI, TPI numbers (Texas)

Organizational providers must provide minimally:

- A current valid state license
- Malpractice face sheet
- Medicare certification (Texas)
- A Facility/Agency application
- Proof of accreditation, or proof of a CompCare site visit, if not accredited

If any additional information is required, Provider Services will contact you. An example of this might be: Any gap in work history. If you have a gap in work history that is longer than 6 months, we will ask for the reason. If there is a gap of longer than 1 year, we will ask you to explain this in writing to the committee.
You may request to review this information and we will share this with you unless it is peer review protected. We cannot share information obtained from the National Practitioners Data Bank (NPDB). You must query the NPDB yourself. However, we will notify you if this information differs from what you stated in your application.

**Your Rights Under Credentialing:**

You may submit written corrections to the National Director of Provider Services within 10 days of our notification of any discrepancy.

You have the right to review information submitted to support our decisions. This includes information from malpractice insurance carriers and state licensing boards, and board certification decisions. As stated above, you have the right to correct erroneous information submitted by another source. We will notify you if any collected information differs from information provided by you in your application. You should contact the National Provider Services Department at the Tampa office in writing within 10 days of our notice. You also have the right to be informed of the status of your applications and may call or write the National Provider Services Department.

**Confidentiality of Credentialing Information:**

In accordance with HIPAA standards, all credentialing information is maintained in a confidential credentialing file. However, from time-to-time your credentialing file may be reviewed by our health plan partners as well as State and Regulatory Agencies.

**Final Decisions Regarding Network Acceptance:**

The Credentialing Committee, which includes representation by actively practicing practitioners, makes the final decision based on all of the information obtained in your credentialing file. This decision will not be made until your file is complete. CompCare contracts with a National Committee for Quality Assurance (NCQA) certified Credentialing Verification Organization (CVO) for primary source verification. This CVO verifies license, education, malpractice insurance, sanctions reports, Medicare opt-out and malpractice issues reported by the NPDB and state licensing boards. The entire credentialing process may take several months and you will not be able to see members until the credentialing decision is made. Your prompt return of all requested information will facilitate the process.

The committee meets on a monthly basis to render decisions to those who have applied and have been approved through the CVO. The entire process from receipt of application to committee review is generally less than 60 days.
You will be notified in a written letter within 60 days of the Credentialing Decision. Your contract with CompCare becomes effective on the date of the Credentialing Committee approval.

CompCare Staff Visiting Your Office:

If it is determined that you may be a ‘potential high volume’ practitioner, and we have not visited your office in the past, we will make a brief visit. The office will be assessed using a standardized tool meeting NCQA requirements and Florida’s Medicaid Contract. The tool is included as an attachment to this manual. We will basically look at the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of treatment record keeping including confidentiality

The office visit is a scoring tool with standards and thresholds for acceptable performance.

Re-credentialing:

Re-credentialing occurs at least every three years beginning at the date of the initial credentialing decision. We will notify you six months prior to your re-credentialing date to complete another application and attestation and to provide all required current valid documents. In between credentialing cycles we will query the NPDB, OIG, Federation of State Medical Boards (FSMB) and state licensing agencies. A history of malpractice or sanction activity does not in and of itself preclude participation in our network and the Credentialing Committee will consider each event. It is also your responsibility to contact us and inform us of any sanctions or limits placed on your license within the notice requirements timeline included in your contract. CompCare will review member complaints and information from quality improvement activities. When we obtain objective evidence of serious quality deficiencies we will notify you and appropriate state and federal agencies. At the time of re-credentialing, we will repeat the credentialing process.

Appeals should be made in writing to the National Provider Services department. You have 45 days from the date of the decision to submit your appeal.

For additional details regarding Credentialing or Re-credentialing, please refer to CompCare’s Provider Manual.
Claims:

We regularly review our claims processes and claims payment as part of the overall quality improvement process. It is essential that all CompCare providers understand the process of coding and filing claims.

The claims submission communicates who was treated and why, the services which were provided, how much is being billed for services, where the services were rendered and by whom. All of these elements are necessary to ensure accurate and timely payments. In addition, this data is essential for state, national, and NCQA reporting requirements mandated by our clients. When claims are incomplete or filed improperly, the payment process is delayed and payment denials will result.

When filing claims, please refer to your authorization mailer for the member/consumer information. This mailer contains information necessary to properly file claims. If you feel that there is an error on your authorization, please contact the CompCare staff listed on the mailer prior to filing the claim. This will assist us to quickly and accurately reimburse you for services rendered.

The following information will provide you with a step-by-step guide to claims submission as well as the forms you will need to submit to CompCare in order to properly process your claim. If you have any questions or need further information, contact your Claims Customer Service at the Tampa office for assistance.

Obligations:

- CompCare will reimburse providers for the delivery of authorized services pursuant to section 641.3155 F.S. including, but not limited to:
  - Claims are considered received on the date the claims are received at our Tampa office (see address listed below).
  - The provider must mail or electronically transfer (submit) the claims to CompCare within six (6) months of:
    - The date of service or discharge form an inpatient setting; or
    - The provider has been furnished with the correct name and address of the enrollee’s health plan.
  - When the Medicaid health plan is the secondary payor, the provider must submit the claim to CompCare within ninety (90) days of the final determination of the primary payor.

- CompCare will reimburse providers for Medicare deductibles and co-insurance payments for Medicare dually eligible members according to the lesser of the following:
  - The rate negotiated with the provider; or
The reimbursement amount as stipulated in section 409.908 F.S.

In accordance with section 409.912 F.S., CompCare will reimburse any Hospital or physician that is outside the health plan’s geographic service area for health plan authorized services provided by the Hospital or physician to Enrollees:
  - At a rate negotiated with the Hospital or physician; or
  - The lesser of the following:
    - The usual and customary charge made to the general public by the Hospital or physician; or
    - The Florida Medicaid reimbursement rate established for the Hospital or physician.

CompCare has claims processing and payment performance metrics including those for quality, accuracy and timeliness and include a process for measurement and monitoring, and for the development and implementation of interventions for improvement. These metrics must be approved by the Agency.

Pursuant to 42CFR447.45, CompCare has a claims processing and payment system, such that:
  - Ninety percent (90%) of clean claims are paid within 30 days from receipt by CompCare.
  - Ninety-nine percent (99%) of clean claims are paid within ninety (90) days of receipt by CompCare.
  - All clean claims are paid within twelve (12) months of receipt by CompCare.

If a claim is paid outside of the timelines indicated above, applicable by State and Federal regulations, interest payments will made to the provider. The amount of the interest payment is based on State and Federal requirements. You may contact Claims Customer Service for further clarification.

Claims Address:

Paper claims should be sent to the following address:

Comprehensive Behavioral Care, Inc.,
ATTN: Claims Department
3405 W. Dr. Martin Luther King Jr. Blvd., Suite 101
Tampa, FL 33607

Please contact our Information Systems Department to obtain information regarding electronic claims submission.
Proper Claims Submission:

Charges for outpatient services should be submitted on a **HCFA 1500 Claim Form**. Charges for inpatient services and facility charges should be submitted on a **UB92 Claim Form**. Both forms should be submitted with the correct coding system, i.e. CPT codes, HCPC codes, Revenue Codes, etc. Outpatient services may be billed on a UB92 if the bill reflects the treating provider who is credentialed to CompCare in box #82 and correct coding in box #4.

In order for CompCare to promptly and accurately process your claim(s), it will be **essential** for the required information to be provided on the **HCFA 1500** claim forms.

**REQUIRED INFORMATION**

**FIELD**

<table>
<thead>
<tr>
<th><strong>HCFA-1500</strong></th>
<th><strong>HCFA-1500</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured’s ID # 1,1A</td>
<td>Patient’s Full Name 2</td>
</tr>
<tr>
<td>Patient’s Date of Birth 3</td>
<td>Insured’s Name 4</td>
</tr>
<tr>
<td>Patient’s Address, City, State, Zip 5</td>
<td>Relationship to Insured 6</td>
</tr>
<tr>
<td>Insured’s Address 7</td>
<td>Patient’s Condition Relation 10a, 10b, 10c</td>
</tr>
<tr>
<td>Insurance Plan Name or Program Name 11a</td>
<td>Insured’s Date of Birth 11b</td>
</tr>
<tr>
<td>Employer’s Name or School name 11c</td>
<td>Another Health Plan Benefit 11d</td>
</tr>
<tr>
<td>Signature or Signature on File (SOF) 12,13</td>
<td>Diagnosis or Nature of Illness21,24e</td>
</tr>
<tr>
<td>CBC Authorization Number 23</td>
<td>Date(s) of Service 24a</td>
</tr>
<tr>
<td>Place of Service 24b</td>
<td>CPT Code(s)/Procedure or Service 24d</td>
</tr>
<tr>
<td>Billing Charges 24f</td>
<td>Number of Days or Units 24g</td>
</tr>
<tr>
<td>Federal tax ID 25</td>
<td>Patients Account No. 26</td>
</tr>
<tr>
<td>Accept Assignment 27</td>
<td>Total Charge 28</td>
</tr>
<tr>
<td>Amount Paid 29</td>
<td>Balance Due 30</td>
</tr>
<tr>
<td>Signature of Person Providing Services and Degrees31</td>
<td>Signature of Person Providing Services and Degrees31</td>
</tr>
<tr>
<td>Name &amp; Address of Facility Where Services Rendered 32</td>
<td>Supplier’s Billing Name etc, and PIN# 33</td>
</tr>
</tbody>
</table>
**BOX K IS FOR INTERNAL USE ONLY AND SHOULD REMAIN BLANK UNLESS OTHERWISE ADVISED TO USE.**

**Clean Claim - Hospital/Facility:**

In order for CompCare to promptly and accurately process your claim(s), it will be **essential** for the required information to be provided on the **UB92** claim forms.

<table>
<thead>
<tr>
<th>REQUIRED INFORMATION</th>
<th>UB92 Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility name and address</td>
<td>1</td>
</tr>
<tr>
<td>Patient Control Number</td>
<td>3</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>4</td>
</tr>
<tr>
<td>Tax ID number</td>
<td>5</td>
</tr>
<tr>
<td>Admission date and discharge</td>
<td>6</td>
</tr>
<tr>
<td>Covered Days</td>
<td>7</td>
</tr>
<tr>
<td>Non-covered Days</td>
<td>8</td>
</tr>
<tr>
<td>Patient’s Name</td>
<td>12</td>
</tr>
<tr>
<td>Patient address</td>
<td>13</td>
</tr>
<tr>
<td>Patient’s Date of Birth</td>
<td>14</td>
</tr>
<tr>
<td>Admission Date, Hour, Type and Source</td>
<td>17, 18, 19, 20</td>
</tr>
<tr>
<td>Discharge Hour and Patient Status</td>
<td>21, 22</td>
</tr>
<tr>
<td>Medical Record Number</td>
<td>23</td>
</tr>
<tr>
<td>Condition Codes</td>
<td>24-30</td>
</tr>
<tr>
<td>Occurrence Codes and dates</td>
<td>32-35</td>
</tr>
<tr>
<td>Occurrence Span codes and dates</td>
<td>36</td>
</tr>
<tr>
<td>Revenue Code(s)</td>
<td>42</td>
</tr>
<tr>
<td>Description of Service(s)</td>
<td>43</td>
</tr>
<tr>
<td>HCPCS (when applicable)</td>
<td>44</td>
</tr>
<tr>
<td>Service Dates</td>
<td>45</td>
</tr>
<tr>
<td>Service Units</td>
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<tr>
<td>Total Charges</td>
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<tr>
<td>Non-covered charges</td>
<td>48</td>
</tr>
<tr>
<td>Payer and/or health plan</td>
<td>50</td>
</tr>
<tr>
<td>Provider Number</td>
<td>51</td>
</tr>
<tr>
<td>Prior Payments</td>
<td>54</td>
</tr>
<tr>
<td>Insured’s Name</td>
<td>58</td>
</tr>
<tr>
<td>Insured’s Member Number</td>
<td>60</td>
</tr>
<tr>
<td>Group or Program Name</td>
<td>61</td>
</tr>
<tr>
<td>CBC Admitting Authorization #</td>
<td>63</td>
</tr>
<tr>
<td>Employer Name</td>
<td>65</td>
</tr>
<tr>
<td>Principle Diagnosis Code(s)</td>
<td>67</td>
</tr>
<tr>
<td>Other Diagnosis Codes</td>
<td>68-75</td>
</tr>
<tr>
<td>Admitting Diagnosis</td>
<td>76</td>
</tr>
<tr>
<td>Principal Procedure Code and date</td>
<td>80</td>
</tr>
<tr>
<td>Other Procedure Codes and dates</td>
<td>81</td>
</tr>
<tr>
<td>Attending Physician</td>
<td>82</td>
</tr>
<tr>
<td>Other Physician</td>
<td>83</td>
</tr>
</tbody>
</table>
Signature of Provider or Representative  85
Date Bill Submitted  86
Itemized bills should be attached to the UB92.

Claims Complaints and Grievances:

Any complaint/grievance regarding claims processing must be submitted to the health plan directly for resolution.

If you wish to file a complaint or formal grievance with Medica Health Plans of Florida, Inc., you can do so in writing or by calling the Customer Service Department at: 1-800-401-2740. The letter or call should include the following information:

- Member’s name and Medica ID-number,
- Member’s address & telephone number,
- A brief description of the grievance,
- Actions taken to resolve the issue; like dates of calls to the Plan.

Please send your signed and dated letter to:

Medica Health Plans of Florida, Inc
Attention: Grievance Coordinator
4000 Ponce de Leon Blvd, Suite 650
Coral Gables, FL 33146

Medica Health Plans of Florida, Inc. grievance coordinator can be contacted Monday through Friday, between the hours of 8 a.m. and 5 p.m., at 1-800-401-2740. Medica Health Plans of Florida, Inc. grievance coordinator will research your problem and complete an investigation, which can include any of the following steps:

i. Clarify information given by the member
ii. Request Provider and office staff information
iii. Research member benefits
iv. Claims review
v. Request medical records and/or verify health guidelines

The provider will receive a letter from Medica Health Plans of Florida, Inc with the decision within 90 days.

**APPEAL TO THE GRIEVANCE COMMITTEE**

If you are not happy with the grievance coordinator’s decision, you have the right to request a review of your case by the Grievance Committee. This appeal must be submitted within 30 days of the first grievance decision. Send a written request to:
Your will receive a letter telling you that your written request has been received. A
date to hear your case will be set by the Medica Health Plans of Florida, Inc Grievance
Committee. You have the option to attend the review in person so that you can give
additional information about your case. If you choose not to attend, the Committee will
still meet and review your case, including other information you may have submitted.
The Grievance Committee will make a decision on your appeal within 30 days.

Providers have the right to request that Medica Health Plans of Florida, Inc continue to
authorize services during your appeal process taking into consideration medical
necessity criteria that may be reviewed via a peer-to-peer process. However, if Medica
Health Plans of Florida, Inc.’s action is upheld, you or the member may be liable for the
cost of any benefits the member continues to receive during the appeal process.

EXPEDITED APPEAL
If the timeframe for the standard appeal would be a risk to the member’s health or
ability to regain the greatest level of function, you can request an expedited appeal. In
this case, a decision will be made and given to you within 72 hours. If the expedited
request is not approved, Medica Health Plans of Florida, Inc will respond to your
grievance within the normal timeframe.

Fraud and Abuse:

CompCare is committed to the prevention, detection, investigation, reporting
and prosecution of fraud and abuse. We ensure the fiscal integrity of our
program and act as a good steward of limited resources through a proactive,
“zero-tolerance” approach to fraud and abuse. Our anti-fraud program promotes
the delivery of quality services through a highly efficient and cost effective
managed behavioral health care system.

When suspected fraud or abuse is detected, CompCare aggressively takes
immediate and decisive action to ensure minimal loss and decrease the risk of
future occurrences. Our Special Investigation Unit (SIU) works closely with
our corporate staff to deny unsubstantiated claims payment. Providers, facilities
or subcontractors who are engaged in suspected fraud or abuse might be
suspended or terminated from our network. CompCare also works together
with government regulatory and law enforcement agencies to prosecute
incidents of suspected fraud when appropriate. Fraud and abuse is an adverse
occurrence which will be reported in the quarterly report to the health plan and
then subsequently to the Agency for Healthcare Administration (AHCA).

Definitions:
Fraud – In general, fraud is any deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to him/herself or another person. This definition also includes any act that constitutes fraud under applicable Federal, state or other law.

Abuse – In general, abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and includes providing services that are not medically necessary or providing services that fail to meet professionally recognized standards for behavioral health care. This definition also includes any act that constitutes abuse under applicable Federal, state or other law.

Claims Review:

CompCare reviews and screens all claims to ensure payment for only authorized, covered and medically necessary services and to identify potential fraud and abuse. Our claims processing system is designed to screen claims during the adjudication process to ensure accurate payment using a series of automated and manual controls and edits. CompCare also employs special prepayment and post-payment utilization controls and edits that include frequency and duration of inpatient and outpatient visits, as well as controls on laboratory, pharmacy and other services in a specific period of time, such as a month or quarter. Claims for services exceeding established parameters are suspended and referred for manual review or audit.

Special Investigation Unit:

When suspected fraud or abuse is detected, CompCare aggressively takes immediate and decisive action to ensure minimal loss and decrease risk of future occurrences. CompCare employs a Special Investigation Unit (SIU) comprised of Certified Fraud Examiners and other professionals whose purpose is to ensure program integrity. We ensure system integrity through an active anti-fraud program designed to prevent, detect, and report incidents of suspected fraud and abuse according to statutory and regulatory requirements. The SIU conducts all anti-fraud activities in a professional and objective manner, maintaining strict confidentiality and integrity during the process. CompCare encourages the SIU to assist our customers in coordinating anti-fraud and abuse efforts.

Professional Review:

CompCare conducts professional reviews to ensure the accuracy and appropriateness of medical necessity determinations. Each provider, facility and other subcontractor is closely monitored and profiled against his/her peers. When warranted, sanctions may be imposed including, but not limited to denial of payment, suspension or termination. CompCare reports serious incidents to
the appropriate Federal and State licensing and regulatory agencies, as well as the National Practitioner’s Data Bank.

Should you encounter an instance of fraud and abuse, please contact the National Provider Services Department at the Tampa office. When you call, please provide as much of the following information as possible:

- The provider’s name
- The service in question
- The date on which the service was supposedly furnished
- The name of the member/consumer who supposedly received the service
- The reason you believe the instance represents fraud and abuse
- Any other relevant information

Cultural Competency:

Diagnostic interpretation of signs and symptoms may vary between geographic regions as well as between cultural/religious sub-groups of the general population. These differences can be problematic with respect to assessing the severity of mental illness and/or substance abuse disorders. Behavior that is not considered deviant in the mainstream culture may be considered deviant in certain sub-groups of the population. Differences also exist between geographic regions regarding standards of practice in all medical disciplines.

Whereas, reasonable differences of opinion can exist with regard to the diagnosis of mental disorders, there is less room for disagreement with regard to the medical necessity of a particular level of care. The criteria presented in this manual were selected to assist the care manager in identifying those signs and symptoms which, by virtue of their nature and/or severity and those therapeutic modalities which by virtue of their nature and/or complexity require that treatment be provided in a particular setting.

At least annually, CompCare assesses linguistic and cultural needs and preferences of its membership. This information comes from the Health Plan, census, member satisfaction, member complaints and internal data identifying access to care concerns. We consider the geographical location of our members and the types of practitioners who are presently in our network. We have defined out network standards for types of professional practitioners, programs and services within our delivery system. Our National Provider Selection Committee meets monthly to further evaluate network needs and initiate the credentialing/re-credentialing process. The Provider Selection Committee and the Credentialing Committee report to the Quality Advisory Council.

In addition, our staff receive Cultural Competency Training at least once per year. This training is conducted by our Human Resource Department.
Member Rights and Responsibilities:

Florida law requires that health care provider or health care facility recognize Florida Medicaid recipient’s rights while they are getting medical care. Members should also respect the our rights as provider or health care facility’s right to expect certain behavior on the part of patients. A summary of member rights and responsibilities follows:

**MEMBER RIGHTS**

- As a patient, you have the right to be treated with courtesy and respect, with appreciation of your dignity, and protection of your need for privacy.
- As a patient, you have the right to a prompt and reasonable response to questions and requests.
- As a patient, you have the right to know who is providing medical services and who is responsible for your care.
- As a patient, you have the right to know what patient support services you can get, and if an interpreter is available if you do not speak English.
- As a patient, you have the right to know what rules and laws apply to your conduct.
- As a patient, you have the right to be given by your health care provider, information about diagnosis, planned course of treatment, alternatives, risks and prognosis.
- As a patient, you have the right to refuse any treatment, except as provided by law.
- As a patient, you have the right to be given, upon request; full information and counseling you need on the availability of known financial resources for your care.
- As a patient, who is eligible for Medicare you have the right to know upon request and in advance of treatment, if the health care provider or health care facility accepts the Medicare assignment rate.
- As a patient, you have the right to get, upon request, before treatment, a reasonable estimate of charges for medical care.
- As a patient, you have the right to get a copy of a reasonable, clear, and understandable detailed bill and, upon request, to have the charges explained.
- As a patient, you have the right to access medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- As a patient, you have the right to treatment for any emergency medical condition that will get worse from failure to provide treatment.
- As a patient, you have the right to know if medical treatment is for experimental research and to give your consent or refusal to take part in such experimental research.
As a patient, you have the right to private handling of medical records and, expect when required by law, be given the chance to approve or refuse their release.

As a patient, you have the right to express grievances about any violation of your rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility, which served you and to the right state-licensing agency.

MEMBER RESPONSIBILITIES:

- As a patient, you have the responsibility to give to your health care provider, to the best of your knowledge, correct and complete information about present complaints, past illnesses, hospital stays, medicines and other health matters.
- As a patient, you have the responsibility to report unexpected changes in your condition to your health care provider.
- As a patient, you have the responsibility to report to your health care provider if you comprehend a thought out course of action and what is expected of you.
- As a patient, you have the responsibility to follow the treatment plan suggested by your health care provider.
- As a patient, you have the responsibility to keep appointments, and when you are unable to do so for any reason, notify the health care provider or the health care facility.
- As a patient, you have the responsibility to answer for your actions if you refuse treatment or do not follow the health care provider’s instructions.
- As a patient, you have the responsibility to assure that the financial obligations of your health care are fulfilled as promptly as possible.
- As a patient, you have the responsibility to follow health care facility rules and laws that affect patient care and conduct.
- As a member, you have the responsibility to inform your health plan if you feel that your Medica Health Plans of Florida membership-id card has been misused, or if you suspect fraudulent activity by a member or provider.
OVERVIEW OF LEVEL OF CARE GUIDELINES

PHILOSOPHY OF CARE

Comprehensive Behavioral Care, Inc. assumes that mental illness is similar to other illnesses; symptoms of mental illness are the result of the interaction of biochemical, psychological and social stressors that result in various degrees of disability or impairment in functioning. Mental wellness/illness is a dynamic balance, which rarely is at one end or the other of the continuum for extended periods of time. The goal of mental health treatment is to decrease the frequency, intensity, and duration of mental impairment/limitation that is the result of these biopsychosocial stressors. Treatment should be provided in the least intrusive manner focusing on maximizing the patient’s degree of freedom to choose treatment options and participate in identifying the goals of treatment.

CompCare identifies high quality providers and facilitates entry into treatment programs that provide the most effective treatment options in the least restrictive environments. Mental health treatment is a means to effectuate a rapid return to a prior level of effective functioning. Occasionally treatment results in the complete amelioration of mental illness symptoms, however, research has shown this to be the exception rather than the rule. The managed treatment model of compare is oriented towards quick, effective decrease in the frequency, intensity, and duration of disabling symptoms.

In some instances treatment episodes begin at one level of intensity (e.g., acute inpatient evaluation and stabilization) and is completed through a less intense, less intrusive, and less restrictive environment such as intensive outpatient programming several days per week followed by individual treatment sessions weekly. The philosophy of CompCare is to be flexible in the utilization of resources and to convert treatment coverage options in order to get the most effective result in the shortest period of time. This may be partially affected by restrictions written into a particular insurance product or plan.

CARE MANAGEMENT PHILOSOPHY

The services at CompCare address a range of identified problems from those of daily living to the impact of severe emotional distress or substance abuse. Providers must have a full range of coordinated services available to meet any need within the continuum of behavioral care.

It is essential that behavioral health care be readily attainable. Services are to be convenient in terms of geographic access, hours of operation, and availability. The early identification and treatment of problems has distinct advantages for the member
and the provider. Early intervention helps to limit complications and deterioration in functioning. Efforts are more focused, and immediate treatment planning occurs thus avoiding inefficient problem resolution and poorly directed care.

CompCare seeks to maximize effective treatment programs and services by using clinical protocols and standards to guide care management decisions at all levels of care. The selection, training, continued support and evaluation of staff are conducted with these standards as a frame of reference.

Built into evaluation, treatment planning, and delivery are level of care guidelines which measure treatment and its outcome. When all parties to treatment, i.e. member, provider and CompCare Care Managers maintain consistency in their expectation of the treatment process, the predictability of positive outcome is greatly increased.

A consensus between providers and members regarding the specific goals and purpose of treatment is essential to maximize a positive treatment outcome. Both should understand the benefits, general purpose, and expectations attendant to the therapeutic process. Issues which brought the member to care must be clearly identified and become a focus of the treatment planning. Goals for change should be objective, time limited, related to the member’s experiences, and agreed upon.

GENERAL CONSIDERATIONS

Authorization for use of benefits for mental health and substance abuse treatment is based on the principles of “medical necessity.” Medical necessity refers to those mental health and substance abuse treatment interventions that are essential for the treatment of a disease, condition or illness, as defined by standard diagnostic nomenclature (ICD9CM and Axis I disorders as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association). Additionally the treatment intervention:

- Can reasonably be expected to restore a member’s condition to a usual and customary level of functioning for that individual;
- Have proven efficacy as defined by standard clinical references and empirical evidence; and
- Are rendered at the most cost-effective and safe level of care within the health care benefit.

Diagnosis alone does not predict treatment modality, nor do treatment modality and diagnosis necessarily predict intensity or setting of care. Specifically the level of clinical instability and the degree of functional impairment, should be determining factors in the development of treatment plans, including the appropriate setting of care and the intensity of provided services.

LOCAL, REGIONAL AND CULTURAL DIFFERENCES

Diagnostic interpretation of signs and symptoms may vary between geographic regions as well as between cultural/religious sub-groups of the general population. These
differences can be problematic with respect to assessing the severity of mental illness and/or substance abuse disorders. Behavior which is not considered deviant in the mainstream culture may be considered deviant in certain sub-groups of the population. Differences also exist between geographic regions regarding standards of practice in all medical disciplines.

Whereas, reasonable differences of opinion can exist with regard to the diagnosis of mental disorders, there is less room for disagreement with regard to the medical necessity of a particular level of care. The criteria presented in this manual were selected to assist the care manager in identifying those signs and symptoms which, by virtue of their nature and/or severity and those therapeutic modalities which by virtue of their nature and/or complexity require that treatment be provided in a particular setting.

**The Importance of Coordination of Care**

CompCare recognizes and strongly endorses the importance of all treatment being coordinated among the behavioral care provider, the Primary Care Physician, CompCare and our health plan partner. The need to insure that this coordination occurs should be assumed for all the following Levels of Care.

**DISCHARGE PLANNING**

Discharge planning begins on admission of each patient to any level of care. The care manager institutes it in order to ensure continuity of care. Discharge planning will be the function of the provider. However, it may be used by the Medical Director(s) and treatment team to negotiate the level of care for the patient when the reviewer and the provider are in disagreement over the appropriateness of care.

The objectives of discharge planning are:

- To facilitate smooth transfer of members from a more intensive level of care to a less intensive level of care;
- To provide continuity of care through planning for the member’s next stage of care;
- To make optimum use of resources and allow staff to focus on active treatment;
- To help staff recognize and plan for the continuing needs of the member;
- To sustain the gains made by the member during treatment by providing, securing and/or utilizing community services as necessary;
- To minimize or prevent a recurrence of the member’s illness;
• To establish procedures to ensure that the discharged member has access to continuing health and/or rehabilitative services as well as other supportive services as may be required to enhance or sustain his/her capacity to function in the community.

**High Risk Program/Case Management**

CompCare recognizes that there are a significant number of members who as a result of their pathology, life circumstances, comorbid conditions and other various complicating factors within the diagnostic profile and treatment planning process require some form of additional intervention and support. For those individuals CompCare utilizes both its High Risk program and/or various other forms of case management interventions that are provided by either network providers or CompCare staff.

The goal of these interventions is to ensure and support that the member successfully engages and completes his/her discharge/treatment plan. These interventions should be considered an option to complement all the following Levels of Care. In addition, it should be noted that while the treatment plan generally is behavioral care in nature, CompCare does support comorbid treatment plans with these programs as well.
Level of Care Guidelines

Mental Health

Children and Adolescents

Medical Necessity

In considering the appropriateness of any level of care, the four basic elements of Medical Necessity should be met:

1. A diagnosis as defined by standard diagnosis nomenclatures (DSM IV or its equivalent in ICD-9-CM) and an individual treatment plan appropriate for the participant’s illness or condition.
2. Can reasonably be expected to restore a Member’s condition to a usual and customary level of functioning for that individual.
3. Have proven efficacy as defined by standard clinical references and empirical experience; and
4. Are rendered at the most cost-effective and safe level of care (within the health care benefit).

Additionally and as outlined in Medicaid guidelines;

1. Be necessary to protect life, to prevent significant illness or significant disability;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

Procedures for Applying UM Criteria

Level of Care Guidelines are designed to be appropriate for the uncomplicated patient and for the very complete delivery system; they may not be appropriate for the patient with complication or for a delivery system that does not include sufficient alternatives to a particular LOC and a particular patient. Therefore, CompCare considers at least the following factors when applying criteria to a given individual:

- Age* (see below)
• Co morbidities: including information obtained in consultation with the Primary Care Physician and/or the Health Plan UM team
• Complications
• Progress of treatment
• Psychological situation
• Home environment, when applicable

The characteristics of the local delivery system available to a particular patient should also be considered:

• Availability of alternative levels of care, such as intensive outpatient programs, outpatient detoxification programs or residential treatment centers in the service area to support the patient after hospital discharge.
• Coverage of benefits for alternative levels of care, such as residential treatment centers where needed
• Ability of local providers to provide all recommended services within the estimated length of stay.

When the above listed member and delivery system complications are identified the Care Management staff are directed to seek internal clinical guidance through case management peer review, discussion with the Director of Clinical Services or the physician advisor.

*Procedures for Applying UM Criteria for children age 5 years and below.

In recent years, there has been an increase in request for services for children who are five years of age and younger. CompCare has developed the following parameters for consideration to properly guide and address the treatment needs of these children and their families/caretakers.

• Initially, all children aged 5 years and below must be evaluated by their pediatrician or primary care physician with particular focus being on insuring that any current difficulties are developmentally age appropriate behaviors. In addition, the presence of any medical condition needs to be ruled out as the source of the behavioral issues.
• Following this assessment, an overall behavioral evaluation needs to be conducted on both the child and the family/caretaker group.
• The clinical information from the above two evaluations then needs to be integrated into a comprehensive goal oriented focused treatment plan that includes the child, family/caretaker, and other relevant individuals; i.e., extended family, school personnel, etc.
• It should be noted that particular attention needs to be paid to maintaining the continuity of care for those at-risk children who are already receiving services within their community; i.e., DCF, DJJ, etc.
• In addition, the provider is encouraged to provide services to those children and families/caretakers who have been identified as being at-risk for developing future behavioral issues.

• All interventions need to have a specific request for authorization that will include the nature of the problem to be addressed, the proposed intervention, the number of sessions requested, and the duration of the intervention.

**OUT PATIENT TREATMENT (OP)**

The goal of this level of care is to reduce or alleviate the member’s symptoms, to return to baseline or improve the level of functioning and/or prevent deterioration.

It is a focused solution-oriented process, and not an open-ended exploration of issues. Treatment focuses on member’s strengths and coping strategies and utilizes community resources and support systems.

Outpatient therapy may involve the member, member and family or support system or the member and a group of other people under the guidance of a mental health or substance abuse clinician.

Outpatient may be provided at the alternative location of in-home. See In-Home Based Services for the additional criteria.

### Initial Authorization - Out Patient Treatment (OP)

1. **Must be met**
   
   □ All components of Medical Necessity must be met

2. & **Must meet ONE**
   
   □ Member reports or expresses a subjective level of distress
   □ Members symptoms result in a significant impairment of functioning but not to the degree that a higher level of care is needed

3. & **BOTH**
   
   □ The member is motivated or agreeable to treatment
   □ A multi-modal approach of the intensive ‘program’ is not necessary to achieve treatment objectives.

### Continued Care – Out Patient (OP)

1. **Must be met**
   
   □ The member has participated in the development of a treatment plan and discharge plan with timelines for expected implementation and completion.
### 2. & Must meet ONE

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<tbody>
<tr>
<td>A</td>
<td>The treatment plan has not led to enough improvement in the member’s condition to allow the member to safely use community resources or a social support system to sustain improvement.</td>
</tr>
<tr>
<td>B</td>
<td>The member has developed new symptoms or the functioning has become impaired so that a new diagnosis and treatment plan is indicated.</td>
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</table>

#### Discharge – Out Patient (OP)

1. Must meet ONE

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<tbody>
<tr>
<td>A</td>
<td>The Guidelines for continued care are not met</td>
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<td>B</td>
<td>The member is uncooperative or non-compliant with treatment and the absence of treatment poses no imminent risk of harm to member or others.</td>
</tr>
<tr>
<td>C</td>
<td>The member’s history shows evidence that additional therapy will not create change or relief of symptoms.</td>
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---

**INTENSIVE OUTPATIENT (IOP)**

Provides a coordinated, intense, comprehensive, multi-modal treatment for members who can maintain some ability to fulfill family, student, or work activities. The member is not an imminent risk for serious bodily injury toward self or others due to aggression. IOP is appropriate for complex clinical situations that would otherwise result in the need for a more restrictive level of care.

Duration and frequency of treatment should be continually evaluated and adjusted depending on the member’s severity of signs and symptoms.

An adjunct to these services may include the alternative location of in-home. See In-Home Based Services for the additional criteria.

#### Initial Authorization - Intensive Outpatient (IOP)

1. Must be met

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<table>
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<td>All components of Medical Necessity must be met</td>
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2. & Must meet ONE

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<tbody>
<tr>
<td>A</td>
<td>Member has deteriorated to a degree that they are unable to perform family, school or work activities at a level appropriate in routine outpatient therapy. The structure provided by IOP is needed to prevent the need for a more restrictive level of care.</td>
</tr>
<tr>
<td>B</td>
<td>The member is experiencing thoughts of self harm intermittently, is able to contract with the provider to access emergency services and is considered at reasonably low – risk so that a more restrictive level of care is not required.</td>
</tr>
<tr>
<td>C</td>
<td>Lack of improvement or non-compliance with outpatient treatment requires interventions of a team to stabilize the member and prevent a more restrictive level of care need.</td>
</tr>
</tbody>
</table>
Continued Stay – Intensive Outpatient (IOP)
1. Must meet ALL

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<tbody>
<tr>
<td>A</td>
<td>The member has participated in the treatment plan and the discharge plan, but continues to suffer from symptoms that led to admission despite active treatment or has developed new symptoms.</td>
</tr>
<tr>
<td>B</td>
<td>The plan of treatment has not led to enough improvement in the member’s condition to allow safe treatment at a less restrictive level of care with sustained improvement.</td>
</tr>
<tr>
<td>C</td>
<td>The member and family (support system) are participating in family therapy at a frequency determined from the clinical presentation of the case.</td>
</tr>
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</table>

Discharge – Intensive Outpatient (IOP)
1. Must meet

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<tbody>
<tr>
<td>A</td>
<td>Continued stay guidelines are no longer met</td>
</tr>
<tr>
<td>B</td>
<td>Appropriate and timely treatment is available at a less restrictive level of care.</td>
</tr>
</tbody>
</table>

23-HOUR CRISIS STABILIZATION

Crisis stabilization is an intensive level of care used to rapidly restore equilibrium with the focus on stabilization of the crisis and developing a plan of care aimed at returning the member to a prior level of functioning.

This level of care requires the patient to be in a hospital setting for a maximum of 23 hours. It is expected that the facility must have around-the-clock nursing and medical care with the ability to perform laboratory, x-ray, etc.

Strong emphasis is placed on assessing the support networks and services available to the member and the member’s willingness and reliability to access and participate in the treatment plan. Family/support system involvement during this period of time is essential.

Initial Authorization: 23 Hour Crisis Stabilization
1. Must meet ONE

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<tbody>
<tr>
<td>A</td>
<td>The member is expressing suicidal ideation and / or hopelessness and helplessness, which must continue to be evaluated for severity and lethality.</td>
</tr>
<tr>
<td>B</td>
<td>The member is expressing threats of harm to others or has acted in unpredictable, disruptive or bizarre ways.</td>
</tr>
<tr>
<td>C</td>
<td>The member is presenting with significant emotional and/ or thought process disturbances, which interfere with judgment leading to serious endangerment of the member.</td>
</tr>
<tr>
<td>D</td>
<td>The member is in current treatment characterized by recurrent self-injury or impaired thinking that responds quickly to structured intervention</td>
</tr>
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</table>
Discharge: 23-Hour Crisis Stabilization
1. Must Meet ONE

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<tbody>
<tr>
<td>A</td>
<td>Member is assessed and stabilized to allow safe transition to a less restrictive level of care</td>
</tr>
<tr>
<td>B</td>
<td>Clinical presentation is unchanged or has deteriorated meeting guidelines for an inpatient level of care.</td>
</tr>
</tbody>
</table>
PARTIAL HOSPITALIZATION

Provides coordinated, intense, comprehensive, multi-modal treatment for members who can be maintained in the community at a minimal level of functioning if closely monitored by their family or support system. Members present no imminent risk of harm to themselves or to others. Medical monitoring for medication regulation and management is a critical element of this level of care.

The treatment provided should include at least one family therapy session per week unless clinically contraindicated.

The Partial Hospital should provide for the academic needs of participants in addition to traditional treatment. This level of care should not be considered as an alternative for members where the school system has not provided the alternative academic setting needed.

Partial hospitalization differs from sub-acute ‘day programs’ where the focus in placed on long-term social rehabilitation and maintenance of members with severe and persistent mental illness.

Support systems should be in place and capable of accessing the need for emergency services. Treatment frequency may be daily, with frequency evaluated and adjusted according to the member’s severity of signs and symptoms.

An adjunct to these services may include the alternative location of in-home. See In-Home Based Services for the additional criteria.

Initial Authorization: Partial Hospitalization

1. **Must be met**
   - All components of Medical Necessity must be met

2. **& Must meet ONE**
   - A The member has demonstrated recent actions of self-harm or harm to others but does not require a 24-hour monitoring environment.
   - B The member has disordered thinking/mood, bizarre behavior, and/or psychomotor agitation/retardation to a degree that interferes with activities of daily living or abilities to fulfill family student or work roles and cannot adequately be addressed at less restrictive level of care.

3. **& Must be met**
   - C There is evidence of:
     - The member having the capacity to attend consistently and comply with the treatment plan,
     - A mental health professional has assessed the member and determined that they
do not require a more intensive level of care,
- The member is capable or contracting for safety and seeking emergency services when and if the need arises when not at the partial program,
- A support system exists that is willing to assist the member

**Continued Stay – Partial Hospitalization**

1. Must meet ALL

| A | The member (and family or support system as appropriate) has participated in the treatment plan, but continues to suffer from symptoms that led to admission or has developed new symptoms related to admission information |
| B | The treatment plan has not led to enough improvement in symptoms to allow the member to safely move to a less restrictive level of care and sustain improvement. (the treatment plan should be reviewed for decreasing frequency of attendance) |
| C | The member and family are participating in family therapy, as often as determined from the clinical information, but not less than once per week. (Multi-family sessions do not substitute for individual family therapy sessions). |

**Discharge – Partial Hospitalization**

1. Must meet ONE

| A | Continued stay guidelines are no longer met |
| B | Appropriate and timely treatment is available at a less restrictive level of care. |

**INPATIENT HOSPITALIZATION**

In-patient settings provide around-the-clock intensive, psychiatric medical and nursing care, continuous observation, and control of behavior as needed to ensure safety to members and others, as well as comprehensive multi-modal therapy for member and member support system.

Alternative less restrictive levels of care should be considered and attempted and a higher level of care should not be authorized solely for ‘convenience’ or as an alternative to incarceration.

It is one of our core beliefs that the child is strongly connected to and dependent upon the family.

- Psychiatric treatment of children and adolescents will have a family treatment component that is integral to the treatment plan and matching in frequency of involvement to the intensity of the level of care required by the child.
- Family therapy is considered to occur in a face-to-face setting and is to occur as is clinically indicated and not only at time of discharge; telephonic conferences are
not considered a substitute for this intervention. The only exceptions to this *which must be physician/senior clinician reviewed* should be made on a clinical basis where either:

1. The parents are considered harmful or unable to adequately care for the participant and immediate alternative placement is being pursued, or
2. The family dynamics are such that intensive involvement may be counter productive during the current treatment intervention.

- Children and adolescents have needs during treatment such as providing for ongoing academic schooling while in treatment to facilitate a transition back to their previous school setting
- For young children (12 years and under), special skill sets of the primary provider are expected-Board Certified Child Psychiatrist or psychiatrist who has completed a Child Psychiatry Residency.
- A more restrictive level of care should not be considered solely on a "convenience" basis alone nor should it automatically be authorized when posed as the alternative to juvenile detention settings.
- It is expected that children 12 years or younger should be admitted to a unit exclusively for children.
- A more restrictive level of care should not be considered solely on a "convenience" basis alone nor should it automatically be authorized when posed as the alternative to juvenile detention settings.

**Admission: Inpatient Hospitalization**

1. **Must be met**
   - All components of Medical Necessity must be met

2. **& Must meet at least ONE**

<table>
<thead>
<tr>
<th></th>
<th>The member</th>
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<tbody>
<tr>
<td>A</td>
<td>- Has recently made a serious suicide attempt as expressed through lethal</td>
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<tr>
<td></td>
<td>intent or plan</td>
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<td></td>
<td>- Is presently expressing suicidal intent with plan and potential means</td>
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<td></td>
<td>- Has recently caused deliberate serious bodily injury to self / or is</td>
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<td>unable to give a valid and reliable safety contract so that 24 hour</td>
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<td>observation and treatment and suicide precautions including potential</td>
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<td></td>
<td>use of seclusion and / or restraints is needed.</td>
</tr>
<tr>
<td>B</td>
<td>The member has assaulted or harmed others causing serious bodily injury or</td>
</tr>
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<td></td>
<td>threatening or intending to do so, so that 24 hour psychiatric treatment</td>
</tr>
<tr>
<td></td>
<td>is needed.</td>
</tr>
<tr>
<td>C</td>
<td>The member has a condition where treatment cannot safely be administered</td>
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<td></td>
<td>in a less restrictive level of care.</td>
</tr>
<tr>
<td>D</td>
<td>The member is presenting with significant emotional and/ or thought process</td>
</tr>
<tr>
<td></td>
<td>disturbances, which interfere with judgment leading to serious</td>
</tr>
<tr>
<td></td>
<td>endangerment of the member.</td>
</tr>
</tbody>
</table>
**Continued Stay, Inpatient**

1. **Must meet ONE**

   A. The member (and as appropriate, the family) has participated in the treatment plan and discharge plan. /the member continues to suffer from symptoms that led to admission despite active treatment – or has developed new symptoms. OR

   B. The member has developed serious side effects to medications or has significant co-morbid medical problems that complicate treatment; requiring around-the-clock nursing care.

2. **& Must meet BOTH**

   A. The member and family (support system) have been participating in active family therapy several times per week (multi-family therapy accounts for no more than one of the family therapy sessions per week). The frequency of these meetings is to be determined from the clinical presentation of the case, but not less than 1-2x/week.

   B. The treatment plan has not led to an improvement that allows the member to be treated safely in a less restrictive level of care.

**Discharge Guidelines, Inpatient**

1. **Must meet ONE**

   A. Continued stay guidelines are no longer met.

   B. Appropriate and timely treatment is available at a less restrictive level of care.

**IN-HOME TREATMENT**

In-Home treatment is to be utilized under the following scenarios:

a. When a member and/or their family have demonstrated an inability to attend treatment as prescribed.

b. When a member and/or their family has a life situation that makes treatment attendance very difficult and the process of getting to the appointments is a barrier to effective treatment.

c. When a member has demonstrated an inability to successfully move from one level of care to another.

d. When a member and/or their family requires a treatment “boost” in between office appointments to solidify treatment compliance and gains.

a. When, in spite of active participation in another level of care, the extent to which issues in the home environment cannot be fully understood or resolved without direct intervention in that environment.
**Initial Authorization - In Home**

1. **Must be met**
   - All components of Medical Necessity must be met

2. & **Must meet ONE**
   - **A**  [ ] Has a "life-circumstance" problem, which requires intervention, but is unable to attend OP therapies due to homebound status where extreme hardship (determined to be detrimental to his/her health) is a factor.
   - **B**  [ ] History indicates that lack of compliance with medication regimen results in requirement for inpatient or partial levels of care. (CAN BE PROVIDED BY LICENSED PSYCHIATRIC NURSE WHO AS PART OF THE CARE PLAN WILL ID AND TRAIN OTHER INDIVIDUAL(s) and/or the Member TO TAKE OVER MEDICATION MONITORING RESPONSIBILITIES)
   - **C**  [ ] Physical or medical issues will not interfere with treatment but may need monitoring.
   - **D**  [ ] This function goes beyond the provision of mental status exam and environmental management and will include behavioral therapy by a licensed mental health therapist, when clinically indicated.
   - **E**  [ ] Acute impairment in social, behavioral, or academic functioning is interfering with compliance with routine OP treatment AND without the home-based structure and support to control the frequency, intensity, and duration of disturbing behaviors, thoughts or feelings, inpatient or partial hospital care is likely to be needed.
   - **F**  [ ] Setting is used for acute stabilization AND coordination of support systems for ongoing care.
   - **G**  [ ] Non-threatening, impaired reality testing that limits ability to function at a less intensive level of treatment.

   & **Must meet BOTH**
   - **H**  [ ] Homebound and not hospitalized
   - **I**  [ ] Emotional and/or behavioral difficulties prevent adequate compliance with OP treatment.
   - **J**  [ ] *At risk for medication and treatment noncompliance and acute functional deterioration at a less intensive level of care.
   - **K**  [ ] Voluntarily accepts services being offered.
   - **L**  [ ] Lesser efforts to provide family and/or significant environmental support systems are unable to meet needs for stability and emotional support.
   - **M**  [ ] High without intervention at this level of care due to medication or outpatient treatment noncompliance.
   - **N**  [ ] Expectation of positive change in symptomatology, which will improve likelihood of benefit from OP treatment and successful attainment of treatment.
goals.

O
- Critical at transition points, such as transition to another level of care when a break in service is likely to result in relapse. Typically provided by mobile crisis teams.

P
- Requests for intervention needs to include problem to be addressed, nature of the intervention, clear and measurable goals for improvement and success, the number of sessions desired, and the timeframe of the intervention.

**Continued Stay, In-Home**

1. **Must meet ONE**

<table>
<thead>
<tr>
<th>A</th>
<th>The member (and as appropriate, the family) has participated in the treatment plan and discharge plan. /the member continues to suffer from symptoms that led to the utilization of in-home treatment or has developed new symptoms. OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>The treatment plan has not led to an improvement that allows the member to be treated safely in a less restrictive level of care.</td>
</tr>
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</table>

**Discharge Guidelines, IN-Home**

1. **Must meet ONE**

<table>
<thead>
<tr>
<th>A</th>
<th>Continued stay guidelines are no longer met.</th>
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<tr>
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**Level of Care Guidelines**

**Mental Health**

**Adult**

**Medical Necessity**

In considering the appropriateness of any level of care, the four basic elements of Medical Necessity should be met:

6. A diagnosis as defined by standard diagnosis nomenclatures (DSM IV or its equivalent in ICD-9-CM) and an individual treatment plan appropriate for the participant’s illness or condition.

7. Can reasonably be expected to restore a Member’s condition to a usual and customary level of functioning for that individual

8. Have proven efficacy as defined by standard clinical references and empirical experience; and

9. Are rendered at the most cost-effective and safe level of care (within the health care benefit).

Additionally and as outlined in Medicaid guidelines;
1. Be necessary to protect life, to prevent significant illness or significant disability.

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigation;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and

10. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

 Procedures for Applying UM Criteria

Level of Care Guidelines are designed to be appropriate for the uncomplicated patient and for the very complete delivery system; they may not be appropriate for the patient with complication or for a delivery system that does not include sufficient alternatives to a particular LOC and a particular patient. Therefore, CompCare considers at least the following factors when applying criteria to a given individual:

- Age
- Comorbidities: including information obtained in consultation with the Primary Care Physician and/or the Health Plan UM team
- Complications
- Progress of treatment
- Psychological situation
- Home environment, when applicable

The characteristics of the local delivery system available to a particular patient should also be considered:

- Availability of alternative levels of care, such as intensive outpatient programs, outpatient detoxification programs or residential treatment centers in the service area to support the patient after hospital discharge.
- Coverage of benefits for alternative levels of care, such as residential treatment centers where needed
- Ability of local providers to provide all recommended services within the estimated length of stay.
When the above listed member and delivery system complications are identified the Care Management staff are directed to seek internal clinical guidance through case management peer review, discussion with the Director of Clinical Services or the physician advisor.
The goal of this level of care is to reduce or alleviate the member’s symptoms, to return to baseline or improve the level of functioning and / or prevent deterioration.

It is a focused solution-oriented process, and not an open-ended exploration of issues. Treatment focuses on member’s strengths and coping strategies and utilizes community resources and support systems.

Outpatient therapy may involve the member, member and family or support system or the member and a group of other people under the guidance of a mental health or substance abuse clinician.

Outpatient may be provided at the alternative location of in-home. See In-Home Based Services for the additional criteria.

Initial Authorization - Out Patient Treatment (OP)
1. Must be met
☐ All components of Medical Necessity met

2. & Must meet ONE

A  Member reports or expresses a subjective level of distress
☐

B  Members symptoms result in a significant impairment of functioning but not to the degree that a higher level of care is needed
☐

3. & BOTH

A  The member is motivated or agreeable to treatment
☐

B  A multi-modal approach of the intensive ‘program’ is not necessary to achieve treatment objectives.
☐

Continued Care – Out Patient Treatment (OP)
1. Must meet

A  The member has participated in the development of a treatment plan and discharge plan with timelines for expected implementation and completion.
☐

2. & must meet ONE

A  The treatment plan has not led to enough improvement in the member’s condition to allow the member to safely use community resources or a social support system to sustain improvement.
☐

B  The member has developed new symptoms or the functioning has become impaired so that a new diagnosis and treatment plan is indicated
☐
Discharge – Out Patient treatment (OP)
1. Must meet ONE

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<tr>
<td>C</td>
<td>The member’s history shows evidence that additional therapy will not create change or relief of symptoms.</td>
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</table>

**INTENSIVE OUTPATIENT (IOP)**

Provides a coordinated, intense, comprehensive, multi-modal treatment for members who can maintain some ability to fulfill family, student, or work activities. The member is not an imminent risk for serious bodily injury toward self or others due to aggression. IOP is appropriate for complex clinical situations that would otherwise result in the need for a more restrictive level of care.

IOP programs must meet a minimum of 3 hours per day/night for usually 3 days per week but can occur up to 7 days a week duration and frequency of treatment should be continually evaluated and adjusted depending on the member’s severity of signs and symptoms.

An adjunct to these services may include the alternative location of in-home. See In-Home Based Services for the additional criteria.

**Initial Authorization - Intensive Outpatient (IOP)**
1. Must be met

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<tbody>
<tr>
<td>☐</td>
<td>All components of Medical Necessity must be met</td>
</tr>
</tbody>
</table>

2. & Must meet ONE

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<tbody>
<tr>
<td>A</td>
<td>Member has deteriorated to a degree that they are unable to perform family, school or work activities at a level appropriate in routine outpatient therapy. The structure provided by IOP is needed to prevent the need for a more restrictive level of care</td>
</tr>
<tr>
<td>B</td>
<td>Lack of improvement or non-compliance with treatment requires interventions of a multi-modal team to stabilize the member and prevent a more restrictive level of care need.</td>
</tr>
</tbody>
</table>

**Continued Stay – Intensive Outpatient (IOP)**
1. Must meet BOTH

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<tbody>
<tr>
<td>A</td>
<td>Despite active participation in treatment, the member continues to experience symptom severity to the extent that treatment cannot be safely administered at a less intensive frequency than that which is provided in a structured Outpatient program.</td>
</tr>
<tr>
<td>B</td>
<td>Despite active participation in treatment, the member’s condition has not improved and it has been determined that continued treatment in a structured Outpatient program continues to be indicated to achieve the identified goals.</td>
</tr>
</tbody>
</table>
Discharge – Intensive Outpatient (IOP)
1. Must meet ONE

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<tr>
<td>A</td>
<td>Continued stay guidelines are no longer met</td>
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<tr>
<td>B</td>
<td>Appropriate and timely treatment is available at a less restrictive level of care.</td>
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23 Hour Crisis Stabilization

Crisis stabilization is an intensive level of care used to rapidly restore equilibrium with the focus on stabilization of the crisis and developing a plan of care aimed at returning the member to a prior level of functioning.

This level of care requires the patient to be in a hospital setting for a maximum of 23 hours. It is expected that the facility must have around-the-clock nursing and medical care with the ability to perform laboratory, x-ray, etc.

Strong emphasis is placed on assessing the support networks and services available to the member and the member’s willingness and reliability to access and participate in the treatment plan.

Initial Authorization – 23-Hour Crisis Stabilization
1. Must meet ONE

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<tr>
<td>A</td>
<td>The member is expressing suicidal ideation and / or hopelessness and helplessness, which must continue to be evaluated for severity and lethality.</td>
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<tr>
<td>B</td>
<td>The member is expressing threats of harm to others or has acted in unpredictable, disruptive or bizarre ways.</td>
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<tr>
<td>C</td>
<td>The member is presenting with significant emotional and / or thought process disturbances which interfere with judgment leading to serious endangerment of the member.</td>
</tr>
<tr>
<td>D</td>
<td>The member is in current treatment characterized by recurrent self-injury or impaired thinking that responds quickly to structured interventions.</td>
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Discharge – 23-Hour Crisis Stabilization
1. Must meet ONE

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<tr>
<td>A</td>
<td>Member is assessed and stabilized to allow safe transition to a less restrictive level of care</td>
</tr>
<tr>
<td>B</td>
<td>Clinical presentation is unchanged or has deteriorated meeting guidelines for an inpatient level of care.</td>
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**INPATIENT HOSPITALIZATION**

In-patient settings provide around-the-clock intensive, psychiatric medical and nursing care, continuous observation, and control of behavior as needed to ensure safety to members and others, as well as comprehensive multi-modal therapy for member and member support system.

Alternative less restrictive levels of care should be considered and attempted and a higher level of care should not be authorized solely for ‘convenience’ or as an alternative to incarceration.

**Initial: Inpatient Hospitalization**

1. Must be met

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- **ALL components of Medical Necessity must be met**

2. & **Must meet at least ONE**

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| A  | The member  
- Has recently made a serious suicide attempt as expressed through lethal intent or plan  
- Is presently expressing suicidal intent with plan and potential means  
- Has recently caused deliberate serious bodily injury to self or is unable to give a valid and reliable safety contract so that 24 hour observation and treatment and suicide precautions including potential use of seclusion and or restraints is needed. |

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<td>B</td>
<td>The member has assaulted or harmed others causing serious bodily injury or is threatening or intending to do so, so that 24 hour psychiatric treatment is needed.</td>
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<tr>
<td>C</td>
<td>The member has a condition where treatment cannot safely be administered in a less restrictive level of care.</td>
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<tr>
<td>D</td>
<td>The member is presenting with significant emotional and/or thought process disturbances, which interfere with judgment leading to serious endangerment of the member or others.</td>
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**Continued Stay: Inpatient Hospitalization**

1. **Must meet ONE**

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<tbody>
<tr>
<td>A</td>
<td>The member has participated in the treatment plan and discharge plan. /the member continues to suffer from symptoms that led to admission despite active treatment – or has developed new symptoms.</td>
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<tr>
<td>B</td>
<td>The member has developed serious side effects to medications or has significant comorbid medical problems that complicate treatment; requiring around – the – clock nursing care.</td>
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2. & Must meet

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<tr>
<td>☐</td>
<td>The treatment plan has not led to an improvement that allows the member to be treated safely in a less restrictive level of care.</td>
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**Discharge Guidelines, Inpatient**

1. Must meet ONE

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**IN-HOME TREATMENT**

In-Home treatment is to be utilized under the following scenarios:

- b. When a member and/or their family have demonstrated an inability to attend treatment as prescribed.
- c. When a member and/or their family has a life situation that makes treatment attendance very difficult and the process of getting to the appointments is a barrier to effective treatment.
- d. When a member has demonstrated an inability to successfully move from one level of care to another.
- e. When a member and/or their family requires a treatment “boost” in between office appointments to solidify treatment compliance and gains.
- f. When, in spite of active participation in another level of care, the extent to which issues in the home environment cannot be fully understood or resolved without direct intervention in that environment.

The following are more specific examples of when In-Home Treatment is indicated.

Continuation of Residential treatment because alternative placement is not available is not justified for continued authorization to the residential program.

**Initial Authorization - In-Home**

1. Must be met

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<td>☐</td>
<td>• Has a &quot;life-circumstance&quot; problem, which requires intervention, but is unable to attend OP therapies due to homebound status where extreme hardship</td>
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</table>
A • History indicates that lack of compliance with medication regimen results in requirement for inpatient or partial levels of care. (CAN BE PROVIDED BY LICENSED PSYCHIATRIC NURSE WHO AS PART OF THE CARE PLAN WILL ID AND TRAIN OTHER INDIVIDUAL(S) and/or the Member TO TAKE OVER MEDICATION MONITORING RESPONSIBILITIES )

B • Physical or medical issues will not interfere with treatment but may need monitoring.

D • Acute impairment in social, behavioral, or academic functioning is interfering with compliance with routine OP treatment AND without the home-based structure and support to control the frequency, intensity, and duration of disturbing behaviors, thoughts or feelings, inpatient or partial hospital care is likely to be needed.

F • Setting is used for acute stabilization AND coordination of support systems for ongoing care.

G • Non-threatening, impaired reality testing that limits ability to function at a less intensive level of treatment.

H • Homebound

I • Emotional and/or behavioral difficulties prevent adequate compliance with OP treatment.

J • Voluntarily accepts services being offered.

K • Lesser efforts to provide family and/or significant environmental support systems are unable to meet needs for stability and emotional support.

L • High without intervention at this level of care due to medication or outpatient treatment noncompliance.

M • Expectation of positive change in symptomatology that will improve likelihood of benefit from OP treatment and successful attainment of treatment goals.

N • Critical at transition points, such as transition to another level of care when a break in service is likely to result in relapse. Typically provided by mobile crisis teams.

O • At risk for medication and treatment noncompliance and acute functional deterioration at a less intensive level of care.

**Continued Stay, In-Home**

1. Must meet ONE

A • The member (and as appropriate, the family) has participated in the treatment plan and discharge plan. /the member continues to suffer from symptoms that led to the
utilization of in-home treatment or has developed new symptoms. OR

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**Discharge Guidelines, IN-Home**

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Clinical Practice Guidelines
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)
SUMMARY OF THE PRACTICE PARAMETERS FOR THE ASSESSMENT AND TREATMENT OF CHILDREN, ADOLESCENTS, AND ADULTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

NOTE: All PCPs who choose to treat ADHD, or any other psychological disorder in their office, should appraise the amount of time and types of therapies they are able to provide for their patients in their practice. A CompCare® network practitioner is always available for an evaluation or consultation.

UPDATE 6/2004
Guideline is available in its entirety through AACAP; Practice Parameters for the assessment and treatment of children, adolescents, and adults with ADHD, October 2001.

FDA WARNING/REGULATORY ALERT

On October 24, 2005, the U.S. Food and Drug Administration (FDA) concluded that the overall risk of liver toxicity from Cylert and generic pemoline products outweighs the benefits of this drug. In May 2005, Abbott chose to stop sales and marketing of Cylert in the U.S. All generic companies have also agreed to stop sales and marketing of this product. Cylert, a central nervous system stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD), is considered second line therapy for ADHD because of its association with life threatening hepatic failure. Health care professionals who prescribe Cylert, or any of its generics, should transition their patients to an alternative therapy. Cylert will remain available through pharmacies and wholesalers until supplies are exhausted. No additional product will be available. See the FDA Web site for more information.

UPDATE 7/2005
No updates reported through AACAP. However, in 2005 the following warning was issued by the FDA.

Adderall XR (amphetamine)

Audience: Neuropsychiatric and other healthcare professionals
FDA issued a Public Health Advisory to notify healthcare professionals that Health Canada, the Canadian drug regulatory agency, has suspended the sale of Adderall XR in the Canadian market. Adderall XR is a controlled release
amphetamine used to treat patients with Attention Deficit Hyperactivity Disorder (ADHD). The Canadian action was based on U.S. post-marketing reports of sudden deaths in pediatric patients. FDA is continuing to evaluate these and other post-marketing reports of serious adverse events in children, adolescents, and adults being treated with Adderall and related products. Adderall XR is approved in the United States for the treatment of adults and pediatric patients 6-12 years old with ADHD, and Adderall, the immediate release formulation of the drug, is approved for pediatric patients with ADHD.

[February 10, 2005 - Drug Information Page - FDA]

UPDATE 6/2006:
Guideline is available in its entirety through AACAP; Practice Parameters for the assessment and treatment of children, adolescents, and adults with ADHD, October 2001.

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- *On September 29, 2005, The U.S. Food and Drug Administration (FDA) directed Eli Lilly and Company (Lilly), the manufacturer of Strattera (atomoxetine), to revise the prescribing information to include a boxed warning and additional warning statements that alert health care providers of an increased risk of suicidal thinking in children and adolescents being treated with this medication. FDA also informed Lilly that a Patient Medication Guide (MedGuide) should be provided to patients when Strattera is dispensed. The MedGuide advises patients of the risks associated with and precautions that can be taken when Strattera is dispensed. Further, pediatric patients being treated with Strattera should be closely observed for clinical worsening, as well as agitation, irritability, suicidal thinking or behaviors, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. See the FDA Web site.

*Note from the National Guideline Clearinghouse and the American Academy of Child and Adolescent Psychiatry (AACAP): On October 3, 2005, AACAP pledged to work with the FDA on its September 29, 2005 advisory regarding Strattera (atomoxetine), to strengthen safeguards for the treatment of children and adolescents with Attention Deficit Hyperactivity Disorder (ADHD). See the AACAP Web site for the complete press release.
DISEASE/CONDITION(S)
Attention-deficit/hyperactivity disorder (ADHD)

GUIDELINE CATEGORY
Management
Treatment

CLINICAL SPECIALTY
Family Practice
Neurology
Pediatrics
Psychiatry
Psychology

INTENDED USERS
Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)
To provide evidence-based recommendations for the treatment of school-aged children with attention-deficit/hyperactivity disorder (ADHD)

TARGET POPULATION
Children 6 to 12 years old with attention-deficit/hyperactivity (ADHD) disorder in primary care settings

Note: This guideline is not intended for children with mental retardation, pervasive developmental disorder, moderate to severe sensory deficits such as visual and hearing impairment, chronic disorders associated with medications that may affect behavior, and those who have experienced child abuse and sexual abuse.

INTERVENTIONS AND PRACTICES CONSIDERED
Treatment/Management
1. Stimulants (first-line treatment):
   a. Methylphenidate: Short-acting (Ritalin, Methylin); Intermediate-acting (Ritalin SR, Metadate ER, Methylin ER); Long-acting (Concerta, Metadate CD, Ritalin LA\(^1\))
   b. Amphetamine: Short-acting (Dexedrine, Dextrostat); Intermediate-acting (Adderall, Dexedrine spansule); Long-acting (Adderall-XR\(^1,2\))

\(^1\)Not approved by the U.S. Food and Drug Administration (FDA) at the time of the publication of the original guideline.

\(^2\)Note from the National Guideline Clearinghouse: On February 10, 2005, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory to notify healthcare professionals that Health Canada, the Canadian drug regulatory agency, has suspended the sale of Adderall XR in the Canadian market. Adderall XR is a controlled release amphetamine used to treat patients with Attention Deficit Hyperactivity Disorder (ADHD). The Canadian action was based on U.S. post-marketing reports of sudden deaths in pediatric patients. FDA is continuing to evaluate these and other post-marketing reports of serious adverse events in children, adolescents, and adults being treated with Adderall and related products. Adderall XR is approved in the United States for the treatment of adults and pediatric patients 6-12 years old with ADHD, and Adderall, the immediate release formulation of the drug, is approved for pediatric patients with ADHD. See the FDA Web site for more information.

2. Antidepressants (second-line treatment)
   a. Tricyclics (TCAs): Imipramine, Desipramine
   b. Bupropion (Wellbutrin, Wellbutrin SR)

3. Behavioral therapy
   a. Positive reinforcement (providing rewards or privileges contingent on the child's performance)
   b. Time-out (removing access to positive reinforcement contingent on performance of unwanted or problem behavior)
   c. Response cost (withdrawing rewards or privileges contingent on the performance of unwanted or problem behavior)
   d. Token economy (combining positive reinforcement and response cost)

4. Education and counseling of children and parents regarding attention-deficit/hyperactivity disorder (ADHD), affects of condition, treatment planning, resources

5. Coordination/collaboration of care among clinicians, parents, teachers, child, other school personnel, such as nurses, psychologists, and counselors, as appropriate, to develop and monitor target outcomes

6. Evaluation and reassessment of children who do not meet target outcomes: evaluation of the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions

7. Periodic systematic follow-up to monitor adherence and response to treatment
MAJOR OUTCOMES CONSIDERED

Efficacy and safety of pharmacological and nonpharmacological interventions

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

- Hand-searches of Published Literature (Primary Sources)
- Hand-searches of Published Literature (Secondary Sources)
- Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

In 1997, the McMaster University Evidence-based Practice Center received the contract for reviewing the literature related to treatment of children with attention-deficit/hyperactivity disorder (ADHD).

The literature search for the McMaster report (see the "Companion Documents" field) was conducted using MEDLINE (from 1966), CINAHL (from 1982), HEALTHStar (from 1975), PsycINFO (from 1984), EMBASE (from 1984), and the Cochrane Library (November 1997). Reference lists of eligible studies and files of members of the research team and partner organizations were also searched.

NUMBER OF SOURCE DOCUMENTS

2405 citations were identified from the McMaster report (see the "Companion Documents" field) of the literature on treatment of attention-deficit/hyperactivity disorder (ADHD); including 92 reports, describing 78 different studies that were identified for further analysis. In addition to the McMaster report, other sources of data were identified.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

For each recommendation, the subcommittee graded the quality of evidence on which the recommendations were based.

Grades of evidence were grouped into 3 categories: good, fair, or poor.

METHODS USED TO ANALYZE THE EVIDENCE

- Review of Published Meta-Analyses
- Systematic Review
DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The McMaster report (see the "Companion Documents" field) focused on the evidence from comparative studies on the effectiveness and safety of pharmacological and nonpharmacological interventions for attention-deficit/hyperactivity disorder (ADHD) in children and adults and whether combined interventions are more effective than individual interventions. This resulted in several questions in the following 7 areas: (1) studies with drug-to-drug comparisons of pharmacological interventions; (2) placebo-controlled studies evaluating the effect of tricyclic antidepressants; (3) studies comparing pharmacological and nonpharmacological interventions; (4) studies evaluating the effect of long-term therapies; (5) studies evaluating therapies for ADHD in adults (i.e., those older than 18 years of age); (6) studies evaluating therapies given in combination; and (7) studies evaluating adverse effects of pharmacological interventions.

Several systematic reviews and meta-analyses have examined placebo-controlled trials of stimulant medication and have established the short-term efficacy of these agents for core symptoms. Placebo-controlled trials of stimulant medication were reviewed in the McMaster report only if they met the criteria for inclusion in any of the other 6 areas. The report also focused on head-to-head comparisons of pharmacological interventions and of pharmacological and nonpharmacological interventions because these were identified as of prime interest to clinicians.

The McMaster report of the literature on treatment of ADHD followed current standards for analyzing research evidence. Studies in this report were selected for evaluation if they were randomized, controlled trials that focused on the treatment of ADHD in humans and if they were published in peer-reviewed journals. Nonrandomized, controlled trials were included only if they provided data on adverse effects that were collected for more than 16 weeks. Studies of multiple conditions that included separate analyses for patients with ADHD were also included.

In addition to the McMaster report, other sources of data were used to support clinical practice guideline recommendations. Although the McMaster report included results of the multimodal treatment study of children with ADHD (MTA), the subcommittee also carefully evaluated the results of this large study separately. The subcommittee used data from the Canadian Coordinating Office for Health Technology Assessment (CCOHTA) study. This review addressed the following 3 major issues related to treatment of children with ADHD: (1) a clinical evaluation of the use of methylphenidate for ADHD; (2) the efficacy of stimulant medications and other therapies; and (3) an economic evaluation of the pharmacological and behavioral therapies for ADHD. Many studies of behavioral interventions for ADHD use crossover techniques, where effects were determined on the same children when they did and did not receive treatment. The McMaster report excluded these crossover trials.
METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations were made at 3 levels. Strong recommendations were based on high-quality scientific evidence or, in the absence of high-quality data, strong expert consensus. Fair and weak recommendations were based on lesser quality or limited data and expert consensus. Clinical options are identified as interventions for which the subcommittee could not find compelling evidence for or against. Clinical options are defined as interventions that a reasonable health care provider might or might not wish to implement in his or her practice.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The draft clinical practice guideline underwent extensive peer review by committees and sections within the American Academy of Pediatrics (AAP), numerous outside organizations, and other individuals identified by the subcommittee. Liaisons to the subcommittee were also invited to distribute the draft to entities within their organizations. Comments were compiled and reviewed by the subcommittee cochairpersons, and relevant changes were incorporated into the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Excerpted by the National Guideline Clearinghouse (NGC)

The guideline contains the following recommendations for the treatment of a child diagnosed with attention-deficit/hyperactivity disorder (ADHD):
Recommendation 1: Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition (strength of evidence: good; strength of recommendation: strong).

Given the high prevalence of ADHD among school-aged children (4% to 12%), primary care clinicians will encounter children with ADHD in their practices regularly and should have a strategy for diagnosis and long-term management of this condition. The primary care of children with ADHD includes attention to the main principles of care for children with any chronic condition, such as:

- Providing information about the condition
- Updating and monitoring family knowledge and understanding on a periodic basis
- Counseling about family response to the condition
- Developmentally appropriate education of the child about ADHD, with updates as the child grows
- Availability to answer family questions
- Ensuring coordination of health and other services
- Helping families set specific goals in areas related to the child's condition and its effects on daily activities
- Linking families with other families with children who have similar chronic conditions as needed and available

As with other chronic conditions, treatment of ADHD requires the development of child-specific treatment plans that describe methods and goals of treatment and means of monitoring care over time, including specific plans for follow-up (see Recommendation 5, below).

Primary care clinicians should educate parents and children about the ways in which ADHD can affect learning, behavior, self-esteem, social skills, and family function. This initial phase of patient education is critical to demystifying the diagnosis and providing parents and children with knowledge about the condition. Education enables parents to work with clinicians, educators, and, in some cases, mental health professionals to develop an effective treatment plan. A therapeutic alliance among clinicians, parents, and the child is enhanced when attention is directed toward cultural values that affect the child's health and health care. The long-term care of a child with ADHD requires an ongoing partnership among clinicians, parents, teachers, and the child. Other school personnel including nurses, psychologists, and counselors can also help with developing and monitoring plans.

Activities specific to the care of children with ADHD include providing current information on the etiology of ADHD, its treatment, long-term outcomes, and effects on daily life and family activities. Thorough family understanding of the problem is essential before discussing treatment options and side effects. What distinguishes this condition from most other chronic conditions managed by primary care clinicians is the
important role that the education system plays in the treatment and monitoring of children with ADHD.

The clinician should be aware of community resources that provide services and know how to make referrals. Primary care providers may offer this information directly or collaborate with other providers, especially subspecialists and mental health providers, to ensure families' access to needed information.

**Recommendation 2**: The treating clinician, parents, and child, in collaboration with school personnel, should specify appropriate target outcomes to guide management (strength of evidence: good; strength of recommendation: strong).

The core symptoms of ADHD (i.e., inattention, impulsivity, hyperactivity) can result in multiple areas of dysfunction relating to a child's performance in the home, school, or community. The primary goal of treatment should be to maximize function. Desired results include:

- Improvements in relationships with parents, siblings, teachers, and peers
- Decreased disruptive behaviors
- Improved academic performance, particularly in volume of work, efficiency, completion, and accuracy
- Increased independence in self-care or homework
- Improved self-esteem
- Enhanced safety in the community, such as in crossing streets or riding bicycles.

Target outcomes should follow from the key symptoms the child manifests and the specific impairments these symptoms cause.

The process of developing target outcomes requires input from parents, children, and teachers, as well as other school personnel where available and appropriate. They should agree on at least 3 to 6 key targets and desired changes as prerequisites to constructing the treatment plan. The goals should be realistic, attainable, and measurable. The methods of treatment and of monitoring change will vary as a function of the target outcomes.

**Recommendation 3**: The clinician should recommend stimulant medication (strength of evidence: good) and/or behavior therapy (strength of evidence: fair), as appropriate, to improve target outcomes in children with ADHD (strength of recommendation: strong).

The clinician should develop a comprehensive management plan focused on the target outcomes.

**Stimulant Medication**

Stimulant medications currently available include short-, intermediate-, and long-acting methylphenidate, and short-, intermediate-, and long-acting dextroamphetamine*. The
latter 2 formulations are mixed amphetamine salts* (75% dextroamphetamine* and 25% levoamphetamine*). Pemoline**, a long-acting stimulant, is rarely used now because of its rare but potentially fatal hepatotoxicity. Primary care clinicians should not use it routinely, and this guideline does not include it as a first- or second-line treatment for ADHD. Table 1 titled "Medications Used in the Treatment of Attention-Deficit/Hyperactivity Disorder" in the original guideline document indicates available medications and their doses.

*Note from the National Guideline Clearinghouse: On February 10, 2005, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory to notify healthcare professionals that Health Canada, the Canadian drug regulatory agency, has suspended the sale of Adderall XR in the Canadian market. Adderall XR is a controlled release amphetamine used to treat patients with Attention Deficit Hyperactivity Disorder (ADHD). The Canadian action was based on U.S. post-marketing reports of sudden deaths in pediatric patients. FDA is continuing to evaluate these and other post-marketing reports of serious adverse events in children, adolescents, and adults being treated with Adderall and related products. Adderall XR is approved in the United States for the treatment of adults and pediatric patients 6-12 years old with ADHD, and Adderall, the immediate release formulation of the drug, is approved for pediatric patients with ADHD. See the FDA Web site for more information.

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Detailed instructions for determining the dose and schedule of stimulant medications are beyond the scope of this guideline. However, a few basic principles guide the available clinical options.

Unlike most other medications, stimulant dosages usually are not weight dependent. Clinicians should begin with a low dose of medication and titrate upward because of the marked individual variability in the dose-response relationship. The first dose that a child's symptoms respond to may not be the best dose to improve function. Clinicians should continue to use higher doses to achieve better responses. This strategy may require reducing the dose when a higher dose produces side effects or no further improvement. The best dose of medication for a given child is the one that leads to optimal effects with minimal side effects. The dosing schedules vary depending on
target outcomes, although no consistent controlled studies compare different dosing schedules. For example, if there is a need for relief of symptoms only during school, a 5-day schedule may be sufficient. By contrast, a need for relief of symptoms at home and school suggests a 7-day schedule.

**Recommendation 3A**: For children on stimulants, if one stimulant does not work at the highest feasible dose, the clinician should recommend another.

At least 80% of children will respond to one of the stimulants if they are tried in a systematic way. Children who fail to show positive effects or who experience intolerable side effects on one stimulant medication should be tried on another of the recommended stimulant medications. The reasons for this recommendation include the following:

- The finding that most children who fail to respond to one medication will have a positive response to an alternative stimulant
- The safety and efficacy of stimulants in the treatment of ADHD compared with nonstimulant medications
- The numerous crossover trials that indicate the efficacy of different stimulants in the same child
- The idiosyncratic responses to medication

Children who fail 2 stimulant medications can be tried on a third type or formulation of stimulant medication. (As indicated in Recommendation 4, below, lack of response to treatment also should lead clinicians to assess the accuracy of the diagnosis and the possibility of undiagnosed coexisting conditions.)

**Behavior Therapy**

Behavior therapy usually is implemented by training parents and teachers in specific techniques of improving behavior.

Behavior therapy then involves providing rewards for demonstrating the desired behavior (e.g., positive reinforcement) or consequences for failure to meet the goals (e.g., punishment). Repetitive application of the rewards and consequences gradually shapes behavior. Although behavior therapy shares a set of principles, it includes different techniques with many of the strategies often combined into a comprehensive program. Refer to the original guideline document for a more detailed discussion of behavior therapy. (Table 2 titled "Effective Behavioral Techniques for Children With Attention-Deficit/Hyperactivity Disorder" in the original guideline document outlines specific behavior therapies that have been demonstrated as effective for ADHD.)

A wide range of clinicians, including psychologists, school personnel, community mental health therapists, or the primary care clinician, can implement behavior therapy directly or train others to implement behavior therapy. Many clinicians prefer to refer to community resources for behavior therapy because behavior therapy with parents is
time-consuming and often does not lend itself to the structure and schedule of the primary care office. Schools may provide behavior therapy with teachers in the context of a U.S. Rehabilitation Act (Section 504) plan or an individual education plan (IEP). Where ADHD has a significant impact on a child's educational abilities, Section 504 requires schools to make classroom adaptations to help children with ADHD function in that setting. Adaptations may include preferential seating, decreased assignment and homework load, and behavior therapy implemented by the teacher.

**Recommendation 4**: When the selected management for a child with ADHD has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions (*strength of evidence: weak; strength of recommendation: strong*).

Most school-aged children with ADHD respond to a therapeutic regimen that includes stimulant medications and/or behavioral/environmental interventions. As noted in Recommendation 3A, above, when one stimulant medication appears ineffective (despite appropriate titration), clinicians should carry out a trial of a second stimulant medication. Continuing lack of response to treatment may reflect: (1) unrealistic target symptoms; (2) lack of information about the child's behavior; (3) an incorrect diagnosis; (4) a coexisting condition affecting the treatment of the ADHD; (5) lack of adherence to the treatment regimen; or (6) a treatment failure. As discussed previously, treatment of ADHD, while decreasing a child's level of impairment, may not fully eliminate the core symptoms of inattention, hyperactivity, and impulsivity. Similarly, children with ADHD may continue to have difficulties with peer relationships despite adequate treatment, and treatment for ADHD frequently shows no association with improvements in academic achievement as measured by standardized instruments.

Evaluation of treatment outcomes requires a careful collection of information from multiple sources, including parents, teachers, other adults in the child's environment (e.g., coaches), and the child. If the target symptoms are realistic and the lack of effectiveness is clear, the primary care clinician should reassess the accuracy of the diagnosis of ADHD. This reassessment should include review of the data initially obtained to make the diagnosis, as described in the American Academy of Pediatrics clinical practice guideline *Diagnosis of Children with Attention-Deficit/Hyperactivity Disorder*. Reassessment usually will require gathering new information from the child, school, and family about the core symptoms of ADHD and their impact on the child's functioning. Clinicians should reconsider other conditions that can mimic ADHD.

As indicated in the diagnostic clinical practice guideline, other conditions commonly accompany ADHD in children, especially oppositional/conduct disorders, anxiety, depression, and learning disorders. These conditions often complicate the treatment of ADHD; clinicians should determine if children who do not respond to treatment have these conditions, either by direct determination in their offices or by referral to appropriate subspecialists (e.g., developmental-behavioral pediatricians, child psychiatrists, psychologists, or other mental health clinicians) or the school system (e.g., school psychologists for learning disabilities) for further evaluation. These
coexisting conditions may not have been fully evaluated initially because of the severity of the ADHD, or the child may have developed another condition with time. Standard psycho-educational testing may clarify the role of learning and language disorders, although other disorders require different assessments.

Treatment plans for ADHD typically require children, families, and schools to enter into a long-term plan that includes a complex medication schedule along with environmental and behavioral interventions. Environmental and behavioral interventions will require ongoing efforts by parents, teachers, and the child. A common cause of nonresponse to treatment is lack of adherence to the treatment plan. Ongoing monitoring of a child's progress should assess the implementation of the plan and determine key problems with, and barriers to, implementation. The clinician should assess adherence to medication and behavior therapy. Lack of adherence is not the equivalent of treatment failure; clinicians should help families find solutions to adherence problems before considering a plan as a failure.

The following can be considered true treatment failure: (1) lack of response to 2 or 3 stimulant medications at maximum dose without side effects or at any dose with intolerable side effects; (2) inability of behavioral therapy or combination therapy to control the child's behaviors; and (3) the interference of a coexisting condition. In each of these situations, referral to mental health specialists who are knowledgeable about behavioral interventions in children is the next step unless the primary care clinician has expertise and experience in managing these situations.

Recommendation 5: The clinician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects, with information gathered from parents, teachers, and the child (strength of evidence: fair; strength of recommendation: strong).

Clinicians should establish a plan for periodic monitoring of the effects of treatment. Plans should include obtaining information about target behaviors, educational output, and medication side effects periodically through office visits, written reports, and phone calls. Monitoring data should include the date of refills, the medication type, dosage, frequency, quantity, and responses to treatment (both medication and behavior therapy). Data can be recorded in a flow sheet, ideally, or in a progress note within each patient's chart. The plan also should include a system for communication among parent, child, and clinician between visits as well as a method for periodic contact with the teacher or other school personnel before a follow-up visit. The monitoring plan should consider normal developmental changes in behavior over time, educational expectations that increase with each grade, and the dynamic nature of a child's home and school environment, because changes in any of these factors may alter target behaviors. All participants should share the plan agenda. Clinicians should provide information and support at frequent intervals in a way that enables the child and family to make informed decisions that promote the child's long-term health and well-being.
Information about target symptoms will continue to come from the parents, child, and teacher. Office interviews, telephone conversations, teacher narratives, and periodic behavior report cards and checklists are among the methods used to obtain needed information. As with the diagnosis of ADHD, clinicians should have active and direct communication with schools. Adherence to medication and the behavior therapy program should be reviewed at each encounter.

The frequency of monitoring depends on the degree of dysfunction, complications, and adherence. Once the child is stable, an office visit every 3 to 6 months allows for assessment of learning and behavior. These visits also allow assessment of potential side effects of stimulants, such as decreased appetite and alteration of weight, height, and growth velocity. Periodic requests for medication refills offer an additional opportunity for communication with the family. At the refill request, the family can be asked about the child’s functioning in school and interpersonal relationships, as well as updates on communication from the school. If any of the follow-up evaluations reveal a decrease in the targeted outcomes, the clinician must first establish that the family is adhering to the treatment plan.

CLINICAL ALGORITHM(S)

An algorithm is provided for the treatment of the school-aged child with attention-deficit/hyperactivity disorder.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations contained in the practice guideline are based on the best available data. Where data were lacking, a combination of evidence and expert consensus was used. Strong recommendations were based on high-quality scientific evidence, or, in the absence of high-quality data, strong expert consensus. Fair and weak recommendations were based on lesser quality or limited data and expert consensus. Clinical options were identified as interventions because the subcommittee could not find compelling evidence for or against. These clinical options are interventions that a reasonable health care provider might or might not wish to implement in his or her practice.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

- Effective management/treatment of attention-deficit/hyperactivity disorder
- Maximization of function in a child with attention-deficit/hyperactivity disorder (ADHD), including:
  - Improvements in relationships with parents, siblings, teachers, and peers
- Decreased disruptive behaviors
- Improved academic performance, particularly in volume of work, efficiency, completion, and accuracy
- Increased independence in self-care or homework
- Improved self-esteem
- Enhanced safety in the community, such as in crossing streets or riding bicycles.

POTENTIAL HARMS

Side effects or adverse reactions to medications.

- **Stimulants.** Side effects occur early in treatment and tend to be mild and short-lived. The most common side effects are decreased appetite, stomachache or headache, delayed sleep onset, jitteriness, or social withdrawal. Most of these symptoms can be successfully managed through adjustments in the dosage or schedule of medication. Approximately 15% to 30% of children experience motor tics, most of which are transient, while on stimulant medications.

Children who receive too high a dose or who are overly sensitive may become overfocused on the medication or appear dull or overly restricted. Many times this side effect can be addressed by lowering the dose. Rarely, with high doses, some children experience psychotic reactions, mood disturbances, or hallucinations.

No consistent reports of behavioral rebound, motor tics, or dose-related growth delays have been found in controlled studies although they are reported clinically. Concern for growth delay has been raised, but a prospective follow-up study into adult life has found no significant impairment of height attained.

- **Tricyclic antidepressants.** Desipramine use has been associated, in rare cases, with sudden death.

CONTRAINDICATIONS

According to the "Physicians' Desk Reference" (Montvale [NJ]: Thomson Medical Economics, 2001) and medication package insert, methylphenidate is contraindicated in children with seizure disorders, a history of seizure disorder, or abnormal electroencephalograms. Studies of the use of methylphenidate have not, however, demonstrated an increase in seizure frequency or severity when it is added to appropriate anticonvulsant medications.
QUALIFYING STATEMENTS

- This guideline is not intended as a sole source of guidance for the treatment of children with attention-deficit/hyperactivity disorder (ADHD). Rather, it is designed to assist the primary care clinician by providing a framework for decision-making. It is not intended to replace clinical judgment or to establish a protocol for all children with this condition, and may not provide the only appropriate approach to this problem.
- The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The American Academy of Pediatrics (AAP) is working on a comprehensive implementation project that will involve written and electronic information and physician/patient education components.

IMPLEMENTATION TOOLS

Clinical Algorithm
Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED QUALITY TOOLS

- National Initiative for Children's Healthcare Quality (NICHQ) Attention-Deficit/Hyperactivity Disorder (ADHD) Practitioners' Toolkit: Diagnosis
- National Initiative for Children's Healthcare Quality (NICHQ) Attention-Deficit/Hyperactivity Disorder (ADHD) Practitioners' Toolkit: Treatment
- National Initiative for Children's Healthcare Quality (NICHQ) Attention-Deficit/Hyperactivity Disorder (ADHD) Practitioners' Toolkit: Parent Information and Support

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)


ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Oct

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics (AAP)

GUIDELINE COMMITTEE

Subcommittee on Attention-Deficit/Hyperactivity Disorder, Committee on Quality Improvement

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

AAP Policies are reviewed every 3 years by the authoring body, at which time a recommendation is made that the policy be retired, revised, or reaffirmed without change. Until the Board of Directors approves a revision or reaffirmation, or retires a statement, the current policy remains in effect.

GUIDELINE AVAILABILITY


Print copies: Available from the American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:


Print copies: Information regarding the availability of print copies is available from the Agency for Healthcare Research and Quality (AHRQ) Web site.

A related American Academy of Pediatrics guideline is also available:


Print copies: Available from AAP, 141 Northwest Point Blvd, P.O. Box 927, Elk Grove Village, IL 60009-0927.

PATIENT RESOURCES

The following is available:


Print copies: Available from the American Academy of Pediatrics, 141 NW Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.
NGC STATUS

This summary was completed by ECRI on May 7, 2002. The information was verified by the guideline developer on June 11, 2002. This summary was updated by ECRI on February 11, 2005, following the release of a public health advisory from the U.S. Food and Drug Administration regarding Adderall and related products. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 26, 2005 following the U.S. Food and Drug Administration advisory on Cylert.

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Major Depressive Disorders
CLINICAL PRACTICE GUIDELINE FOR MAJOR DEPRESSIVE DISORDER IN ADULTS

Introduction

Depression is a serious disorder that interferes more with social and physical functioning than do such chronic physical illnesses as hypertension, diabetes, arthritis, and back pain. It is associated with significant morbidity and a 15% mortality rate from suicide. Those who suffer from the disorder often find it to be a chronic and recurrent condition. The lifetime risk for females is 20-26%; and for males is 3-12%; with a 3-5% prevalence in the United States. Within 5 years of recovering from an episode of major depression, more than 60% of the patients will have a recurrence; a relapse within the first 6 months after recovery places patients at high risk for chronicity. Individuals who have had two episodes have a 70% chance of having a third, and individuals who have had three episodes have a 90% chance of having a fourth. Current literature suggests lifetime maintenance on antidepressant following 3 distinct episodes of depression.

NOTE: The following summary is intended to provide an overview of the organization and scope of recommendations in the practice guideline. The treatment of patients with major depressive disorder requires the consideration of many factors and cannot adequately be reviewed in a brief summary. The reader is encouraged to consult the relevant portions of the full-text guideline when specific treatment recommendations are sought. This summary is not intended to stand by itself.

UPDATE 06/2004:
The guideline for the Treatment of Patients with Major Depressive Disorder, 2nd Edition, originally published in April 2000 is available in its entirety through the APA. As of this date no guideline watch found summarizing significant develops since publication of this guideline.

FDA WARNING/REGULATORY ALERT
On October 15, 2004, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory, asking manufacturers of all antidepressant drugs to revise the labeling for their products to include a boxed warning and expanded warning statements that alert health care providers to an increased risk of suicidality (suicidal thinking and behavior) in children and adolescents being treated with these agents, and additional information about the results of pediatric studies. FDA also informed these.
manufacturers that it has determined that a Patient Medication Guide (MedGuide), which will be given to patients receiving the drugs to advise them of the risk and precautions that can be taken, is appropriate for these drug products. See the FDA Web site for more information.

**UPDATE 07/2005:**
Since the publication in 2000 of APA’s Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2nd Edition), two important safety concerns have emerged (hepatotoxicity with nefazodone, and suicide risk and antidepressants), and two new antidepressants have been approved for use (escitalopram and duloxetine).

Additionally, black box warnings have been added to all SSRIs due to an increased risk of suicidal thinking or behaviors associated with these medications.

Results from meta-analyses and well-designed trials of St. John’s wort and ECT have become available. The new information on St. John’s Wort gives mixed reviews for the efficacy of this treatment. The information on ECT reinforces the use of this treatment in cases of depression.

Recent studies have also lent support to psychotherapy and other psychosocial treatments as a means to treat depression. Studies give mixed reviews to combined treatment of psychopharmacology and psychotherapy, but it is suggested that the combination is more effective than medication alone.

Continuation and maintenance treatment is supported by recent studies for those at high risk of recurrent depression. Studies also support various strategies to augment antidepressants for those with an inadequate response to treatment. Lastly, studies have provided certain strategies for use of antidepressants in older adults.

**UPDATE 6/2006:**

**REGULATORY ALERT**

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- On May 12, 2006, GlaxoSmithKline (GSK) and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information for Paxil and Paxil CR. These labeling changes relate to adult patients, particularly those who are younger adults.
A recent meta-analysis conducted of suicidal behavior and ideation in placebo-controlled clinical trials of paroxetine in adult patients with psychiatric disorders including Major Depressive Disorder (MDD), other depression and non-depression disorders. Results of this analysis showed a higher frequency of suicidal behavior in young adults treated with paroxetine compared with placebo. Further, in the analysis of adults with MDD (all ages), the frequency of suicidal behavior was higher in patients treated with paroxetine compared with placebo. This difference was statistically significant; however, as the absolute number and incidence of events are small, these data should be interpreted with caution. All of the reported events of suicidal behavior in the adult patients with MDD were non-fatal suicide attempts, and the majority of these attempts (8 of 11) were in younger adults aged 18-30. These MDD data suggest that the higher frequency observed in the younger adult population across psychiatric disorders may extend beyond the age of 24.

It is important that all patients, especially young adults and those who are improving, receive careful monitoring during paroxetine therapy regardless of the condition being treated. See the FDA Web site for more information.

- On December 8, 2005, the U.S. Food and Drug Administration (FDA) has determined that exposure to paroxetine in the first trimester of pregnancy may increase the risk for congenital malformations, particularly cardiac malformations. At the FDA's request, the manufacturer has changed paroxetine's pregnancy category from C to D and added new data and recommendations to the WARNINGS section of paroxetine's prescribing information. FDA is awaiting the final results of the recent studies and accruing additional data related to the use of paroxetine in pregnancy in order to better characterize the risk for congenital malformations associated with paroxetine.

Physicians who are caring for women receiving paroxetine should alert them to the potential risk to the fetus if they plan to become pregnant or are currently in their first trimester of pregnancy. Discontinuing paroxetine therapy should be considered for these patients. Women who are pregnant, or planning a pregnancy, and currently taking paroxetine should consult with their physician about whether to continue taking it. Women should not stop the drug without discussing the best way to do that with their physician. See the FDA Web site for more information.

- On September 27, 2005, GlaxoSmithKline (GSK) and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information for Paxil and Paxil CR Controlled-Release Tablets to describe the results of a GSK retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy. This study suggested an increase in the risk of overall major congenital malformations for paroxetine as compared to other antidepressants [OR 2.2;
95% confidence interval, 1.34-3.63]. Healthcare professionals are advised to carefully weigh the potential risks and benefits of using paroxetine therapy in women during pregnancy and to discuss these findings as well as treatment alternatives with their patients. See the FDA Web site for more information.

- On July 1, 2005, in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory to update patients and healthcare providers with the latest information on this subject. Even before the publication of these recent reports, FDA had already begun the process of reviewing available data to determine whether there is an increased risk of suicidal behavior in adults taking antidepressants. The Agency has asked manufacturers to provide information from their trials using an approach similar to that used in the evaluation of the risk of suicidal behavior in the pediatric population taking antidepressants. This effort will involve hundreds of clinical trials and may take more than a year to complete. See the FDA Web site for more information.

**DISEASE/CONDITION(S)**

Major Depressive Disorder

**GUIDELINE CATEGORY**

Management
Treatment

**CLINICAL SPECIALTY**

Neurology
Psychiatry

**INTENDED USERS**

Physicians

**GUIDELINE OBJECTIVE(S)**

1. To assist the physician faced with the task of implementing specific antidepressant treatment(s) for an adult patient diagnosed as suffering from major depression according to the criteria for this disorder defined in DSM-IV.
2. To summarize the specific forms of somatic, psychotherapeutic, psychosocial, and educational treatments that have been developed to deal with major depressive disorder and its various subtypes.
TARGET POPULATION

Adults (over the age of 18) suspected of having major depressive disorder

INTERVENTIONS AND PRACTICES CONSIDERED

The various interventions considered for treatment of a major depressive episode may be used alone or in combination. Furthermore, the psychiatrist must decide whether to conduct treatment on an outpatient, partial hospitalization, or inpatient basis.

Psychotherapeutic Interventions

- Psychotherapeutic management
- Psychodynamic psychotherapy and psychoanalysis
- Brief psychodynamic psychotherapy
- Interpersonal therapy
- Behavior therapy
- Cognitive behavior therapy
- Marital therapy and family therapy
- Group therapy

Somatic Interventions

- Antidepressant medications including:
  1. Cyclic antidepressants, which include the tricyclic antidepressants as well as the tetracyclic antidepressant medication maprotiline
  2. Selective serotonin-reuptake inhibiting antidepressants, which currently include fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram
  3. Monoamine oxidase (MAO) inhibitors, which include the commonly used phenelzine, isocarboxazid, and tranylcypromine
  4. Other antidepressant medications, including bupropion, nefazodone, trazodone, venlafaxine, mirtazapine, and reboxetine (for which U.S Food and Drug Administration approval is anticipated)
  5. St. John's wort (whole plant product)
- Electroconvulsive therapy
- Light therapy

MAJOR OUTCOMES CONSIDERED

- Control of depressive symptoms
- Rate of remission, relapse and recurrence of major depression
- Morbidity and mortality due to major depression
METHODOLOGY
METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Studies were identified through an extensive review of the literature by using MEDLARS for the period 1971-1999. The key words used were affective disorder, major depression, depressive disorder, seasonal affective disorder, melancholia, unipolar depression, endogenous depression, dysthyemic disorder, dysthymia, postpartum depression, pseudodementia, antidepressant medications, tricyclic antidepressive agents, monoamine oxidase inhibitors, lithium, and electroconvulsive therapy and included the concepts of melancholia, neurotic depression, and major depression. In addition, the key words for the psychotherapy search were psychotherapy (not otherwise specified); behavior therapy, including aversive therapy, biofeedback (psychology), cognitive therapy, desensitization (psychologic), implosive therapy, and relaxation techniques (meditation); psychoanalytic therapy, including existentialism, free association, transactional analysis, psychotherapy (brief); and psychotherapy (group), including family therapy and marital therapy. Major review articles and standard psychiatric texts were consulted. The Agency for Health Care Policy and Research Evidence Report on Treatment of Depression--Newer Pharmacotherapies (Rockville [MD]: Agency for Health Care Policy and Research. March 1999 [Evidence Report/Technology Assessment: no: 7]) was reviewed in its entirety. Review articles and relevant clinical trials were reviewed in their entirety; other studies were selected for review on the basis of their relevance to the particular issues discussed in this guideline.

NUMBER OF SOURCE DOCUMENTS

169 source documents

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review
DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and practice experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified at falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] indicates recommended with substantial clinical confidence.

[II] indicates recommended with moderate clinical confidence.

[III] indicates options that may be recommended on the basis of individual circumstances.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline is written in successive drafts, each being revised on the basis of comments received from an increasing number of people: early drafts are sent to the
Steering Committee and about 50 expert reviewers; later drafts are sent to members of the Assembly, the District Branches, the Board of Trustees, and other American Psychiatric Association (APA) components. Drafts are available to any APA member by request through their District Branch. In addition, individual experts who are not APA members along with relevant professional, scientific, and patient organizations are asked to review the drafts. Once all comments have been considered, a final draft is sent to the Assembly and Board of Trustees for their approval. Thus each guideline is reviewed by hundreds of psychiatrists and other interested parties prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the efficacy of the treatment for the disorder and conditions described.

[I] indicates recommended with substantial clinical confidence.

[II] indicates recommended with moderate clinical confidence.

[III] indicates options that may be recommended on the basis of individual circumstances.

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient [I]. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of subsequent major depressive episodes. Psychiatrists initiating treatment for major depressive disorder have at their disposal a number of medications, a variety of psychotherapeutic approaches, electroconvulsive therapy (ECT), and other treatment modalities (e.g., light therapy) that may be used alone or in combination. The psychiatrist must determine the setting that will most likely ensure the patient's safety as well as promote improvement in the patient's condition [I].

A. Psychiatric Management

Psychiatric management consists of a broad array of interventions and activities that should be instituted by psychiatrists for all patients with major depressive disorder [I]. Regardless of the specific treatment modalities selected, it is important to continue providing psychiatric management through all phases of treatment. The specific components of psychiatric management that must be addressed for all patients include performing a diagnostic evaluation, evaluating safety of the patient and others, evaluating the level of functional impairments, determining a treatment setting, establishing and maintaining a therapeutic
alliance, monitoring the patient's psychiatric status and safety, providing education to patients and families, enhancing treatment adherence, and working with patients to address early signs of relapse.

B. Acute Phase

1. Choice of an initial treatment modality

In the acute phase, in addition to psychiatric management, the psychiatrist may choose between several initial treatment modalities, including pharmacotherapy, psychotherapy, the combination of medications plus psychotherapy, or electroconvulsive therapy [I]. Selection of an initial treatment modality should be influenced by both clinical (e.g., severity of symptoms) and other factors (e.g., patient preference).

a. Antidepressant medication

If preferred by the patient, antidepressant medications may be provided as an initial primary treatment modality for mild major depressive disorder [I]. Antidepressant medications should be provided for moderate to severe major depressive disorder unless electroconvulsive therapy is planned [I]. A combination of antipsychotic and antidepressant medications or electroconvulsive therapy should be used for psychotic depression [I].

b. Psychotherapy

A specific, effective psychotherapy alone as an initial treatment modality may be considered for patients with mild to moderate major depressive disorder [II]. Patient preference for psychotherapeutic approaches is an important factor that should be considered in the decision. Clinical features that may suggest the use of psychotherapeutic interventions include the presence of significant psychosocial stressors, intrapsychic conflict, interpersonal difficulties, or a comorbid axis II disorder [I].

c. Psychotherapy plus antidepressant medications

The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder [I]. In addition, patients who have had a history of only partial response to adequate trials of single treatment modalities may benefit from combined treatment. Poor
adherence with treatments may also warrant combined treatment modalities.

d. Electroconvulsive therapy

Electroconvulsive therapy should be considered for patients with major depressive disorder with a high degree of symptom severity and functional impairment or for cases in which psychotic symptoms or catatonia are present [I]. Electroconvulsive therapy may also be the treatment modality of choice for patients in whom there is an urgent need for response, such as patients who are suicidal or refusing food and nutritionally compromised [II].

2. Choice of specific pharmacologic treatment

Antidepressant medications that have been shown to be effective are listed in the full-text guideline document -- see the table titled "Commonly Used Antidepressant Medications" [II]. The effectiveness of antidepressant medications is generally comparable between classes and within classes of medications. Therefore, the initial selection of an antidepressant medication will largely be based on the anticipated side effects, the safety or tolerability of these side effects for individual patients, patient preference, quantity and quality of clinical trial data regarding the medication, and its cost (for more information, see Section V.A.1 of the original guideline document) [I]. On the basis of these considerations, the following medications are likely to be optimal for most patients: selective serotonin reuptake inhibitors (SSRIs), desipramine, nortriptyline, bupropion, and venlafaxine. In general, monoamine oxidase inhibitors (MAOIs) should be restricted to patients who do not respond to other treatments because of their potential for serious side effects and the necessity of dietary restrictions. Patients with major depressive disorder with atypical features are one group for whom several studies suggest monoamine oxidase inhibitors may be particularly effective; however, in clinical practice, many psychiatrists start with selective serotonin reuptake inhibitors in such patients because of the more favorable adverse effect profile.

a. Implementation

When pharmacotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided (e.g., psychotherapy) [I]. Once an antidepressant medication has been selected, it can be started at the dose levels suggested in the full-text guideline document -- see the table titled "Commonly Used Antidepressant
Medications" [I]. Titration to full therapeutic doses generally can be accomplished over the initial week(s) of treatment but may vary depending on the development of side effects, the patient's age, and the presence of comorbid illnesses. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition, and safety [I] (see "Management of Medication Side Effects" in the original guideline document.). Factors to consider in determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports, and the presence of comorbid general medical problems. Visits should also be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.

b. Failure to respond

If at least moderate improvement is not observed following 6-8 weeks of pharmacotherapy, a reappraisal of the treatment regimen should be conducted [I]. Section II.B.2.2.b in the original guideline document reviews options for adjusting the treatment regimen when necessary. Following any change in treatment, the patient should continue to be closely monitored. If there is not at least a moderate improvement in major depressive disorder symptoms after an additional 6-8 weeks of treatment, the psychiatrist should conduct another thorough review. An algorithm depicting the sequence of subsequent steps that can be taken for patients who fail to respond fully to treatment is provided in the full-text guideline document --see "Acute Phase Treatment of Major Depressive Disorder."

3. Choice of specific psychotherapy

Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder, although rigorous studies evaluating the efficacy of psychodynamic psychotherapy have not been published [II]. When psychodynamic psychotherapy is used as a specific treatment, in addition to symptom relief, it is frequently associated with broader long-term goals. Patient preference and the availability of clinicians with appropriate training and expertise in the specific approach are also factors in the choice of a particular form of psychotherapy.
a. Implementation

When psychotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided (e.g., medication treatment) [I]. The optimal frequency of psychotherapy has not been rigorously studied in controlled trials. The psychiatrist should take into account multiple factors when determining the frequency for individual patients, including the specific type and goals of psychotherapy, the frequency necessary to create and maintain a therapeutic relationship, the frequency of visits required to ensure treatment adherence, and the frequency necessary to monitor and address suicidality. The frequency of outpatient visits during the acute phase generally varies from once a week in routine cases to as often as several times a week. Regardless of the type of psychotherapy selected, the patient's response to treatment should be carefully monitored [I].

If more than one clinician is involved in providing the care, it is essential that all treating clinicians have sufficient ongoing contact with the patient and with each other to ensure that relevant information is available to guide treatment decisions [I].

b. Failure to respond

If after 4-8 weeks of treatment at least a moderate improvement is not observed, then a thorough review and reappraisal of the diagnosis, complicating conditions and issues, and treatment plan should be conducted [I]. Figure 3 and Section II.B.3.b. in the original guideline document review the options to consider.

4. Choice of medications plus psychotherapy

In general, the same issues that influence the specific choice of medication or psychotherapy when used alone should be considered when choosing treatments for patients receiving combined modalities [I].

5. Assessing the adequacy of response

It is not uncommon for patients to have a substantial but incomplete response in terms of symptom reduction or improvement in functioning during acute phase treatments. It is important not to conclude the acute phase of treatment for such patients, as a partial response is often associated with poor functional outcomes. When patients are found to have not fully responded to an acute phase treatment, a change in
treatment should be considered as outlined in the full-text guideline document -- see "Acute Phase Treatment of Major Depressive Disorder" [II].

C. **Continuation Phase**

During the 16-20 weeks following remission, patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse [I]. In general, the dose used in the acute phase is also used in the continuation phase. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase [I]. Use of electroconvulsive therapy in the continuation phase has received little formal study but may be useful in patients for whom medication or psychotherapy has not been effective in maintaining stability during the continuation phase [II]. The frequency of visits must be determined by the patient's clinical condition as well as the specific treatments being provided.

D. **Maintenance Phase**

Following the continuation phase, maintenance-phase treatment should be considered for patients to prevent recurrences of major depressive disorder [I]. Factors to consider are discussed in the full-text guideline document -- see the table titled "Considerations in the Decision to Use Maintenance Treatment" -- and Section II.D of the original guideline document.

In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase [II]. In general, the same full antidepressant medication doses are employed as were used in prior phases of treatment; use of lower doses of antidepressant medication in the maintenance phase has not been well studied. For cognitive behavioral therapy and interpersonal therapy, maintenance phase treatments usually involve a decreased frequency of visits (e.g., once a month). The frequency of visits in the maintenance phase must be determined by the patient's clinical condition as well as the specific treatments being provided. The frequency required could range from as low as once every 2-3 months for stable patients who require only psychiatric management and medication monitoring to as high as multiple times a week for those in whom psychodynamic psychotherapy is being conducted.

E. **Discontinuation of Active Treatment**

The decision to discontinue active treatment should be based on the same factors considered in the decision to initiate maintenance treatment, including the probability of recurrence, the frequency and severity of past episodes, the persistence of dysthymic symptoms after recovery, the presence of comorbid
disorders, and patient preferences [I]. In addition to the factors listed in the full-text guideline document -- see the table titled "Considerations in the Decision to Use Maintenance Treatment" and the table titled "Risk Factors for Recurrence of Major Depressive Disorder" -- patients and their psychiatrists should consider the patient's response, in terms of both beneficial and adverse effects, to maintenance treatments.

**CLINICAL ALGORITHM(S)**

The original guideline contains a clinical algorithm depicting the sequence of subsequent steps that can be taken for patients who fail to respond fully to treatment.

**EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The recommendations delineated in this guideline are in some instances based on data distilled from randomized prospective clinical trials, while in other areas they are based on individual case reports along with the collective experience and judgment of well-regarded senior psychiatrists.

To identify the type of evidence supporting the major recommendations in the full-text practice guide, each is keyed to one or more references and each reference is followed by a letter code in brackets that indicates the nature of the supporting evidence. Minor recommendations not keyed to references may be assumed to be based on expert opinion.

The bracketed letter following each reference indicates the nature of the supporting evidence, as follows:

[A] Randomized controlled clinical trial  
[B] Nonrandomized case-control study  
[C] Nonrandomized cohort study  
[D] Clinical report with nonrandomized historical comparison groups  
[E] Case report or series  
[F] Expert consensus  
[G] Subject review subsuming multiple categories A-E
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved patient care.
- Education of psychiatrists, other medical and mental health professionals, and the general public about appropriate and inappropriate treatments.
- Identification of those areas where critical information is lacking and where research could be expected to improve clinical decisions.
- Aid those charged with overseeing the utilization and reimbursement of psychiatric services with developing more scientifically based and clinically sensitive criteria.

POTENTIAL HARMS

Side effects of antidepressant medication:

- Dizziness, sedation, and feeling medicated: Associated with many antidepressants. Amitriptyline, doxepin, and trazodone are experienced as most sedating, norriptyline and amoxapine as less sedating, and fluoxetine, sertraline, bupropion, protriptyline, and desipramine as least sedating.
- Peripheral anticholinergic side effects: The most common undesirable consequences of muscarinic blockade are dry mouth, impaired ability to focus at close range, constipation, and urinary hesitation. All tricyclic antidepressants have some degree of antimuscarinic action; desipramine has the lowest potency in this regard. While monoamine oxidase inhibitors are not anticholinergic, their side effects may resemble anticholinergic symptoms.
- Weight gain: Tricyclic antidepressants, monoamine oxidase inhibitors, and lithium all have the capacity to induce weight gain. Bupropion, fluoxetine, sertraline, and trazodone do not usually induce weight gain, and bupropion and fluoxetine (and perhaps sertraline) may actually cause some (usually transient) degree of appetite and weight loss.
- Sexual dysfunction: While loss of erectile or ejaculatory function in men and loss of libido and anorgasmia in both sexes may be complications of virtually any antidepressant agent, these side effects appear to be most common with the monoamine oxidase inhibitors, fluoxetine, and probably sertraline and to be least common with bupropion.
- Neurological side effects, such as seizures or myoclonus: Overall, for most agents and for patients without specific risk factors who receive antidepressants administered within the recommended dose range, the risk of seizures is most often reported to be less than 1 percent. Fluoxetine, sertraline, trazodone, and monoamine oxidase inhibitors carry a lower risk of inducing seizures. Risk increases with dose for all offending agents. Tricyclic antidepressants sometimes induce mild myoclonus.
- Cardiovascular effects, such as orthostatic hypotension: A common side effect of tricyclic antidepressants, trazodone, and monoamine oxidase inhibitors.
Insomnia and anxiety: Fluoxetine may precipitate or exacerbate anxiety and sleep disturbance in some patients. Anxiety may be minimized by introducing the agent at a low dose; insomnia may be effectively treated by the addition of trazodone, up to 100 mg at bedtime. Other antidepressants, including desipramine and bupropion, may also increase anxiety in some patients.

**Side effects associated with electroconvulsive therapy**

- Cognitive: transient postictal confusional state and anterograde and retrograde memory interference.
- Cardiovascular: transient rise in heart rate, cardiac workload, and blood pressure.
- Cerebrovascular: transient rise in intracranial pressure and blood-brain barrier permeability.

**Side effects associated with light therapy**

- Possibly include headache, eye strain, irritability, and insomnia, adverse ocular effects.

**Subgroups Most Likely to be Harmed:**

*The following subgroups would be most likely to be harmed by electroconvulsive therapy:*

- Patients with the presence of significant cardiovascular disease. Electroconvulsive therapy is an indication for caution and general medical or cardiology consultation.
- Patients with evidence of increased intracranial pressure or cerebrovascular fragility. These patients should only receive electroconvulsive therapy after careful general medical, neurological, or neurosurgical evaluation.

*The following subgroups are more vulnerable to light therapy and would require attention and consultative supervision of the appropriate specialist if light therapy were conducted:*

- Patients with retinal diseases or ordinary photosensitivity.
- Patients with systemic lupus erythematosus.
- Patients with a history of skin cancer.

*Patients with the following concurrent general medical disorders are most likely to be adversely affected by pharmacotherapy:*

- *Asthma.* Individuals with asthma who receive monoamine oxidase inhibitors should be cautioned regarding interactions with sympathomimetic bronchodilators.
- **Cardiac disease.** The presence of specific cardiac conditions complicates or contraindicates certain forms of antidepressant medication therapy, notably use of tricyclic agents; the cardiac history should therefore be carefully explored before the initiation of medication treatment.

- **Dementia.** Individuals with dementia are particularly susceptible to the toxic effects of muscarinic blockade on memory and attention. Therefore, individuals suffering from dementia generally do best when given antidepressant medications with the lowest possible degree of anticholinergic effect, e.g., bupropion, fluoxetine, sertraline, trazodone, and, of the tricyclic agents, desipramine or nortriptyline. Alternatively, some patients do well given stimulants in small doses.

- **Epilepsy.** Consideration should be given to concomitant prescription of an antiepileptic (or elevating the dose of an existing antiepileptic).

- **Glaucoma.** Medications with anticholinergic potency may precipitate acute narrow-angle glaucoma in susceptible individuals (i.e., those with shallow anterior chambers). Patients with glaucoma receiving local miotic therapy may be treated with antidepressant medications, including those possessing anticholinergic properties, provided that their intraocular pressure is monitored during antidepressant medication treatment.

- **Hypertension.** Antihypertensive agents and tricyclic antidepressant medications may interact to either intensify or counteract the effect of the antihypertensive therapy. The action of antihypertensive agents that block alpha receptors (e.g., prazosin) may be intensified by antidepressant medications that block these same receptors, notably the tricyclic antidepressants and trazodone. Tricyclic antidepressants may antagonize the therapeutic actions of guanethidine, clonidine, or alpha-methyldopa. Concurrent antihypertensive treatment, especially with diuretics, increases the likelihood that tricyclic antidepressants, trazodone, or monoamine oxidase inhibitors will induce symptomatic orthostatic hypotension. Beta-blockers, especially propranolol, may be a cause of major depressive disorder in some patients; individuals who have become depressed after initiation of treatment with one of these medications should be changed to another antihypertensive regimen. Dose-dependent elevations in blood pressure with venlafaxine are usually mild, although more severe elevations have been observed, making this agent less preferable in patients with hypertension.

- **Obstructive uropathy.** Benzodiazepines, trazodone, and monoamine oxidase inhibitors may retard bladder emptying.

- **Parkinson's disease.** Amoxapine, an antidepressant medication with dopamine-receptor blocking properties, should be avoided for patients who have Parkinson's disease. Lithium may in some instances induce or exacerbate parkinsonian symptoms. Bupropion, in contrast, exerts a beneficial effect on the symptoms of Parkinson's disease in some patients but may also induce psychotic symptoms, perhaps because of its agonistic action in the dopaminergic system. Monoamine oxidase inhibitors (other than selegiline, also known as L-deprenyl, a selective type B monoamine oxidase inhibitor recommended in the treatment of Parkinson's disease) may adversely interact with L-dopa products. Selegiline loses its specificity for monoamine oxidase-B
in doses greater than 10 mg/day and may induce serotonin syndrome when given in higher doses in conjunction with serotonin-enhancing antidepressant medications.

**CONTRAINDICATIONS**

Prostatism and other forms of bladder outlet obstruction are relative contraindications to the use of antidepressant medication compounds with antimuscarinic effects.

**QUALIFYING STATEMENTS**

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment course must be made by the physician in light of the clinical data presented by the patient and the diagnostic and treatment options available.

**IMPLEMENTATION OF THE GUIDELINE**

**DESCRIPTION OF IMPLEMENTATION STRATEGY**

The American Psychiatric Association develops derivative products including patient guides, quick reference guides, and quality of care indicators with research studies to evaluate the effectiveness of the guideline.

**IMPLEMENTATION TOOLS**

Clinical Algorithm
Patient Resources
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)


ADAPTATION

Not applicable: The guideline was not adapted from another source.

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1993 (revised 2000; reviewed 2005)

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American Psychiatric Association - Medical Specialty Society

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GUIDELINE COMMITTEE

Work Group on Major Depressive Disorder

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: T. Byram Karasu, M.D., Chair; Alan Gelenberg, M.D.; Arnold E. Merriam, M.D.; Philip Wang, M.D., Dr.P.H.
FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities many contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of the available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Office of Research. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

GUIDELINE STATUS

This is the current release of the guideline. It is a revision of a previously issued version (Practice guideline for major depressive disorder in adults. Washington [DC]: American Psychiatric Press, Inc; 1993. 51 p., and Am J Psychiatry 1993 Apr;150[4 Suppl]:1-26).

According to the guideline developer, this guideline is still considered to be current as of February 2005, based on a review of literature published since the original guideline publication.

In addition, a Guideline Watch, which summarizes significant developments in practice since the publication of the original guideline, was published in 2005 and is available from the American Psychiatric Association Web site (see also the "Availability of Companion Documents" field below).

GUIDELINE AVAILABILITY


Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

Additionally, a continuing medical education (CME) course is available online at the American Psychiatric Association Web site.

PATIENT RESOURCES

The following is available:


Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on December 1, 1998. The information was verified by the guideline developer on January 11, 1999. The summary was updated by ECRI on February 1, 2001. The updated summary was verified by the guideline developer as of March 9, 2001. This summary was updated by ECRI on August 15,
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Preferred Practice Guidelines
Attention Deficit Hyperactivity Disorder (ADHD)
Introduction

According to the National Institutes of Health, more evidence supports that Attention Deficit Hyperactivity Disorder (ADHD) does not come from the home and environment, but from biological causes. Not all children or adults from a dysfunctional families or unstable homes have ADHD, just as not all children or adults with ADHD come from unstable, dysfunctional families.

Over the years, theories proven to be incorrect as the cause of ADHD have been minor head injuries or undetected brain damage or ‘too much sugar’ or food additives. Additionally, ‘too much television’, food allergies, ‘poor parenting’ or ‘poor schools’ do not cause ADHD.

ADHD Causes

As researchers continue to search for the cause of ADHD, there have been links to ADHD associated with mother’s use of cigarettes, alcohol and other drugs during pregnancy. There have also been links to environmental toxins, such as ‘lead’. Other research is showing a genetic connection with children with ADHD having at least one close relative with ADHD (25-35%), fathers with ADHD having at least one child with ADHD and the majority of twins both sharing ADHD. Finally, there have been links found between a person’s ability to pay attention and their level of brain activity. Using positron emission tomography (PET) scans, researchers have identified that people with inattention appear to have a lower level of brain activity with less use of glucose within the brain.

ADD vs. ADHD

ADD (Attention Deficit Disorder) is a generic term used for the three subtypes of ADHD.

ADHD (Attention Deficit Hyperactivity Disorder) is a diagnosis applied to “children and adults who consistently display certain characteristic behaviors over a period of time”.

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These behaviors usually include:
- Distractibility: poor sustained attention to tasks
- Impulsivity: impaired impulse control and delay of gratification
- Hyperactivity: excessive activity and physical restlessness

There are three subtypes of ADHD called
- Combined Type,
- Predominantly Inattentive Type, and
- Predominantly Hyperactive-Impulsive Type.

**ADHD Identified and Diagnosed**

Children growing and maturing at different rates are often first identified by the parents or teachers as being inattentive or hyperactive at home or at school and the family doctor or pediatrician is usually the first healthcare professional asked about these behaviors. The family doctor or pediatrician as the Primary Care Physician (PCP) is often the best professional to make a thorough and comprehensive assessment because prior wellness and illness checks and family interactions have allowed the PCP to establish a baseline in which to compare the child’s current behavior.

The PCP providing federally required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services can best identify if the child should first have a hearing or vision check, a nutritional review or body systems or educational milestone assessment. The PCP’s established relationship with the family allows for coordination of medical needs and information gathering to proceed quickly. The PCP can fulfill his obligation to assure the availability and accessibility of required health care resources and to help the children and families effectively use those resources.

With an increase in ADHD consumer education and more socially acceptable links to a medical rather than behavioral cause, adults are also seeking treatment for their long-standing symptoms that have been unsuccessfully treated by medication or therapy for depression, anxiety or manic-depression.

**Integrated Medical and Behavioral Healthcare**

Recognizing that ADHD a) has biological and possibly genetic links, b) is usually first identified within the family and school systems, c) is first seen by the family PCP and d) has treatment barriers associated with education and social
acceptance; CompCare has initiated collaborative pilot programs with several health plans to meet the needs of children and adults with ADD. Incorporating CompCare’s Clinical Practice Guideline for ADHD, the following processes have been instituted.

- Referrals, regardless if from a member, parent, school, PCP or relevant caregiver, receive an initial evaluation from a CompCare network provider to establish an accurate diagnosis.

An interview (a parent interview for children and adolescents) is the core of the assessment process. Queries about family history of ADHD, other psychiatric disorders, and psychosocial adversity (e.g., poverty, parental psychopathology or absence, family conflict) are especially important because of their relationship to prognosis.

It is essential to obtain reports of behavior, learning, and attendance at school, as well as grades and test scores for children and adolescents. Parent and teacher rating scales yield valuable information efficiently. The most commonly used are the parent-completed Child Behavior Checklist, the Teacher Report Form (TRF) of the Child Behavior checklist, the Conners Parent and Teacher Rating Scales, and the ADD-H. According to AACAP Practice Guideline, ADHD is a clinical diagnosis; there is no test for ADHD. Neuropsychological tests are useful to evaluate specific deficits, but are not sufficiently helpful to be routinely performed. EEG or neurological consultation is indicated only in the presence of focal signs or clinical suggestions of seizure disorder or degenerative condition.
• Upon coordination with the health plan, the member receives a complete medical evaluation from the health plan’s medical network provider to rule out any underlying medical issues.

A Medical evaluation should be done to include a complete medical history and a physical examination within the past 12 months. History should include the patient's use of prescribed, over-the-counter, and illicit drugs. Vision or hearing deficits should be ruled out. If clinical or environmental risk factors are present, lead level should be measured. Thyroid function tests are indicated only in the presence of clinical findings. There are no data to support the use of hair analysis or the routine measurement of zinc.

A variety of disorders can be mistaken for ADHD or can co-occur. Physical causes of poor attention may include impaired vision or hearing, seizures, sequelae of head trauma, acute or chronic medical illness, poor nutrition, or insufficient sleep. Anxiety disorders or realistic fear, depression, or the sequelae of abuse or neglect may interfere with attention. Mental retardation, borderline intellectual functioning and learning disabilities are commonly mislabeled ADHD although they often co-occur. Various drugs (including Phenobarbital) may interfere with attention.

• After evaluation and diagnosis is complete, the member, the participating medical and behavioral healthcare providers and relevant family, school and/or caregivers establishes a comprehensive treatment plan that outlines treatment options and provides the educational, medical and emotional help they will need.
Within the constraints of the member’s benefits, the following medical and psychiatric interface will occur:

1. The member’s health plan in coordination with CompCare will provide educational ADHD handouts and community support group information.
2. The member’s health plan in coordination with consultative services by CompCare to the PCP or neurologist will provide medication management.
3. CompCare, through its provider network of behavioral healthcare professionals, in coordination with the member’s family, school and/or relevant caregivers will provide individual, family and/or group therapy to manage those symptoms that are adversely impacting the member’s daily activities.

Menninger Clinic Seminar Recorded on America Online, Online Psych Forum, Peter Jaksa, Ph.D., 1998


Section 504 of Public Law 94-142 and the Americans Disability Act (ADA) require the school systems who receive federal funding to complete assessment, special planning and accommodations for those children and adolescents who are determined to have disabilities.

Individuals with Disabilities Education Improvement Act of 2004; H.R. 1350, Section 614, Evaluations, Eligibility Determinations, Individualized Education Programs and Education Placements.
Psychological Testing
Introduction

Psychological Testing is used in gaining information about various facets of a patient’s functioning including perceptual, cognitive, verbal and motoric functioning. The goal of this testing is to clarify the type, nature, and extent of an individual’s condition with the specific intent of developing a more effective treatment plan. Psychological tests provide standardized, valid, and reliable tools and methods to obtain this data.

As distinguished from psychological testing, behavioral assessment includes the use of standardized interview techniques with a patient and reliable reporting sources, as well as naturalistic observation.

While psychological testing may add importantly to the assessment of complex and difficult treatment problems, psychological testing never replaces the need for a thorough direct examination of the member by a behavioral health professional.

Criteria

Based upon our philosophy on patient assessment and psychological testing, Comprehensive Behavioral Care has outlined specific criteria against which the clinical appropriateness and necessity of testing is determined.

Psychological testing may be a valuable aspect of clinical assessment when the normal assessment process, i.e. clinical interview, mental status exam and medical and psychiatric history of the member including prior clinical assessment does not provide sufficient evidence to make a substantiated diagnosis, develop interventions, and formulate a meaningful treatment plan. Accordingly, psychological testing is not considered to be a routine part of the assessment process for any service or to confirm a diagnosis. However, it may have an important role in determining the appropriate course of treatment when the therapist is continuing to question how this information will assist in the treatment planning and contribute to the outcome.
CompCare requires that requests for psychological testing are targeted to specific diagnostic questions and does not endorse the use of “standard” testing batteries. Only tests that have been validated to answer the specific referral question(s) will be considered.

Who can perform psychological testing?

Individuals with specific training and experience in the testing tools to be used should only conduct psychological testing. Accordingly, only licensed psychologists or psychometricians will be authorized to conduct psychological testing.

Information required completing a Psychological Testing Request:

- What is the diagnostic question(s) that are specific to the testing request and are these questions directly relevant to the patient’s behavioral care?
- Are the tests requested appropriate to the diagnostic question(s)?
- Are all of the tests requested necessary to answer the diagnostic question(s)?
- What is the amount of time required completing the testing?
- How will the information determined impact the patient’s plan of care?

Issues in determining appropriateness and necessity for Psychological Testing:

- Is the diagnosis clear without testing?
- Does the patient’s functional level appear related to evident stressors?
- Are other sources available for the same information?
- Is the information to be gained more accurately identifies or validates the diagnosis and thus significantly alters the development/modification of the treatment plan?
- Does testing appear to be primarily intended for educational purposes?
- Is there a need to differentiate the diagnosis?
- Is there underlying organicity or budding psychosis?
- Is there a need to assess for malingering or secondary gain issues?
- Has the patient failed to respond to current treatment efforts?
- Would testing be more clinically effective or cost efficient than continued observation or other treatment intervention?
- Has similar testing been conducted within the past year?

Other relevant issues:

- Is psychological testing covered in the patient’s insurance benefit?
- Has a thorough behavioral assessment been completed?
- Can the issue be assessed using brief assessment tools in the normal course of a treatment
session (e.g., brief self-assessment scales, etc.)?

Psychological Testing versus NeuroPsychological Testing

NeuroPsychological Testing (neuro-psych testing) includes the use of specific tests that look at the cognitive and physical aspects of the patient. Neuro-psych testing focuses on assessing the body and neurological deficits. Neuro-psych testing will look at pinpointing the organic source of a behavioral disorder while psychological testing addresses the personality component. For example, psychological testing reviewing behavioral responses can be used to rule out disorders of depression, psychosis, anxiety and schizophrenia while neuro-psych testing focuses on brain functioning and disorders such as dementia and Alzheimer’s.

It is CompCare's position that requests for neuro-psych testing need to be considered by CompCare when the specialist (neurologist, psychiatrist, psychologist, etc.) identified for the given clinical presentation belongs to behavioral health. As ordered by a neurologist, neuro-psych testing is covered through the member’s medical rather than behavioral health benefits.

When complicated presentations make it difficult to determine who is the appropriate specialist for a case, mixed service protocols between the health plan and CompCare establish guidelines of responsibility for the various assessments, follow-ups and costs of these difficult cases. Therefore, CompCare reviews complicated presentations on a case by case basis in conjunction with the health plan.

Psychological Testing and Medical/Surgical Procedures

CompCare receives periodic requests for psychological testing to determine the suitability of a patient for various medical procedures. These may include bariatric surgery, organ transplants and other similar procedures.
It is CompCare’s policy that psychological testing never replaces the need for a thorough direct examination of the member by a behavioral health professional within the CompCare provider network. A diagnostic interview with the patient and any relevant significant others should be conducted to determine the presence of symptoms and behavior patterns that would be contraindications to a medical procedures. Those contraindicating symptoms and behavior patterns would include the presence of active substance abuse, documented non-compliance with medical care, and/or significant psychopathology. The medical necessity for psychological testing would only be considered if there remains an outstanding question as to the degree of psychopathology and/or potential for treatment non-compliance.

Bariatric Surgery

Increasing in popularity, the procedure of bariatric surgery is a recognized sub-interest in the field of General Surgery. The American Society for Bariatric Surgery is recognized by the American College of Surgeons and is also a specialty surgical society within the Specialty & Service Society section of the American Medical Association.

In 1997, the American Society for Bariatric Surgery established guidelines for the selection, treatment and risks for a bariatric surgery candidate. According to these guidelines, selection of the Bariatric Surgery candidate begins by recommending, “Surgical treatment should be offered to patients who are severely obese, well informed, motivated, and acceptable operative risks. The patient should be able to participate in treatment and long term follow-up. Some patients with manifest psychopathology that jeopardizes an informed consent and cooperation with long term follow up may need to be excluded.” ¹
Although, the guidelines state there are two possible reasons for pre-operative psychological testing prior to bariatric surgery, “One is to weed out those with significant psychopathology in whom surgery would be contra-indicated” and “the other to pre-select those in whom the surgery is likely to be a success”. The guidelines further add, “Unfortunately psychological evaluation has proven of limited value in both these situations”.

For pre-operative assessment requests, CompCare defers to the American Society for Bariatric Surgery’s Guidelines and recommends and authorizes an evaluation for a thorough direct examination of the member by a behavioral health professional within the CompCare provider network.


Psychological Testing and Attention Deficit Hyper Activity Disorder (ADHD)

In 1997, the American Academy of Child and Adolescent Psychiatry (AACAP) established its Clinical Practice Guidelines for ADHD. CompCare adopted those ADHD guidelines because of the large population of children and adolescents with each of their health plans. The guideline recommendations include:

1) An interview (a parent interview for children and adolescents) is the core of the assessment process. Queries about family history of ADHD, other psychiatric disorders, and psychosocial adversity (e.g., poverty, parental psychopathology or absence, family conflict) are especially important because of their relationship to prognosis.
2) It is essential to obtain reports of behavior, learning, and attendance at school, as well as grades and test scores for children and adolescents. Parent and teacher rating scales yield valuable information efficiently. The most commonly used are the parent-completed Child Behavior Checklist, the Teacher Report Form (TRF) of the Child Behavior checklist, the Conners Parent and Teacher Rating Scales, and the ADD-H.

3) A Medical evaluation should be done to include a complete medical history and a physical examination within the past 12 months. History should include the patient's use of prescribed, over-the-counter, and illicit drugs. Vision or hearing deficits should be ruled out. If clinical or environmental risk factors are present, lead level should be measured. Thyroid function tests are indicated only in the presence of clinical findings. There are no data to support the use of hair analysis or the routine measurement of zinc.

According to AACAP Practice Guideline, ADHD is a clinical diagnosis; there is no test for ADHD. Neuropsychological tests are useful to evaluate specific deficits, but are not sufficiently helpful to be routinely performed. EEG or neurological consultation is indicated only in the presence of focal signs or clinical suggestions of seizure disorder or degenerative condition.

A variety of disorders can be mistaken for ADHD or can co-occur. Physical causes of poor attention may include impaired vision or hearing, seizures, sequelae of head trauma, acute or chronic medical illness, poor nutrition, or insufficient sleep. Anxiety disorders or realistic fear, depression, or the sequelae of abuse or neglect may interfere with attention. Mental retardation, borderline intellectual functioning and learning
disabilities\(^2\) are commonly mislabeled ADHD although they often co-occur. Various drugs (including Phenobarbital) may interfere with attention.

For ADHD psychological testing requests, CompCare defers to the adopted Clinical Practice Guidelines for ADHD and recommends and authorizes an evaluation for a thorough direct examination of the member by a behavioral health professional within the CompCare provider network.


\(^2\) Section 504 of Public Law 94-142 and the Americans Disability Act (ADA) require the school systems who receive federal funding to complete assessment, special planning and accommodations for those children and adolescents who are determined to have disabilities.

Individuals with Disabilities Education Improvement Act of 2004; H.R. 1350, Section 614, Evaluations, Eligibility Determinations, Individualized Education Programs and Education Placements.
Eating Disorders
Eating Disorders are described as severe disturbances in eating behavior which manifest as refusal to maintain a minimally normal body weight (Anorexia Nervosa) or repeated episodes of binge eating followed by inappropriate compensatory behaviors such as vomiting, fasting, or excessive exercise (Bulimia Nervosa). The disorder usually begins during the teenage years and occurs more in females.

What information is required in managing a request for Anorexia or Bulimia Nervosa?

Treatment settings for eating disorders can range from outpatient counseling to inpatient hospitalization. Evaluation of patients with eating disorders is essential for determining the appropriate treatment setting. Professionals who specialize in eating disorder should perform the evaluation and treatment planning. Patients should undergo an extensive psychosocial history that includes the assessment for psychological, sexual, and physical abuse. Patients should also be assessed for the following symptoms and behaviors: Mood, anxiety, and personality disorders, obsessions and/or compulsions, shoplifting and impulsive disorders, and substance abuse. Medical status must be evaluated as part of the treatment plan.

**DSM Criteria**

Anorexia Nervosa 307.1
   A. Refusal to maintain body weight at or above a minimally normal weight for age and height.
   Several predominant personality styles have strong associations with prognosis.
   B. Intense fear of gaining weight or becoming fat, even though underweight.
   C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or denial of seriousness of the current low body weight
Distinctions have been made between “typical” and “atypical” anorexia nervosa. “Atypical” anorexia nervosa may have a somewhat better prognosis due in part to the fact that they are more willing to engage and remain in treatment.

D. In postmenarcheal females, amenorrhea for at least 3 consecutive months. Although amenorrhea is one of the DSM-IV-TR criteria for anorexia nervosa, many patients with preserved menstruation but all of the other features of anorexia nervosa have a similar course as those who become amenorrheic.

**Bulimia Nervosa 307.51**

A. Recurrent episodes of binge eating
   1. Eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   2. A sense of lack of control over eating during the episode.

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting or excessive exercise.

C. The binge eating and inappropriate compensatory behavior both occur on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

**Treatment Goals**

*Anorexia Nervosa*

Treatment goals include a) restoring healthy weight, b) treating physical complications, c) restoring healthy eating patterns and providing education on healthy nutrition, d) correction of maladaptive thoughts, attitudes, and feelings related to the disorder, e) treating comorbid psychiatric and medical conditions.

Effective treatment of anorexia nervosa should not rely on psychotropic medications as the primary mode of treatment. After weight gain and the psychological effects of malnutrition begin to subside, an assessment for antidepressant medication is appropriate for the patient.

Patients should be monitored medically during re-feeding. Monitoring includes assessment of vital signs, food and fluid intake and output, electrolytes, edema, rapid weight gain, congestive heart failure and gastrointestinal symptoms. Cardiac ultrasound may be considered since some studies showed a high incident of silent pericardial effusion on ECHO exam.
Bulimia Nervosa

Treatment goals include a) reduction/elimination of binge eating and purging, b) nutritional counseling to minimize food restriction and to increase the variety of food eaten, c) cognitive behavioral psychotherapy to address symptoms of the eating disorder and underlying psychiatric conditions, d) medications to improve comorbid psychiatric symptoms and improve interpersonal functioning, e) encourage and monitor for healthy exercise patterns.

Many patients with uncomplicated bulimia nervosa do not require inpatient treatment. Indications for higher levels of care include severe, disabling symptoms that have not remitted in an outpatient setting, serious concurrent medical problems, suicidal ideation, and severe concurrent substance abuse. Studies have continued to demonstrate effectiveness of CBT and for interpersonal therapy in both individual and group settings. Increasing attention has been given to the use of “self-care” strategies or manuals that are available. These may be used as the first line of intervention. Certain SSRI medications have shown to be effective in bulimia nervosa.

Medical and Psychiatric Management

Medical implications for inpatient hospitalization

- Weight <75% of standard (acute weight decline with food refusal in children and adolescents)
- Heart rate <40 bpm (40-49 in children and adolescents)
- Blood pressure < 90/60 mm Hg (<80/50 mm Hg in children and adolescents)
- Glucose <60 mg/dL
- Potassium <3 mEg/L (Hypokalemia in children and adolescents)
- Electrolyte imbalance
- Temperature <97.0 F
- Dehydration
- Kidney, liver, or cardiovascular organ compromise
- Hypophosphatemia in children and adolescents

Psychiatric indicators for inpatient hospitalization

- Suicidal ideation and plan (history of suicidal attempts)
- Poor motivation to recover
- Failed treatment attempts at lower levels of care
- Need for supervision during and after meals and in bathrooms
- Additional comorbid psychiatric or substance disorders that require treatment

What is CompCare’s position on using Medical or Psychiatric Benefit for treatment?
Evaluate the needed level of psychiatric care according to the Level of Care guidelines. If the patient is in a higher level of care for medical reasons only, consult with the medical carrier. Factors influencing the decision to hospitalize on a psychiatric or a general medical unit include the patient’s general medical status, the skill and abilities of the local psychiatric and general medical staff, and the availability and quality of intensive outpatient, partial and aftercare programs to address medical and psychiatric issues. It may be necessary to use a general medical facility to address acute medical conditions and add psychiatric consultation to monitor and treat the behavioral issues. When psychiatric symptoms are acute, it may better serve patient safety and expedite recovery to hospitalize in a psychiatric facility with a medical consult to monitor the medical condition.

In choice of treatment sites, increasing attention is being given to the essential features of various treatment programs. For example, effectiveness of partial hospital programs has been directly related to their intensity. While 12-hour, 6 day per week programs may approach inpatient programs in effectiveness, programs with fewer hours and fewer days of the week have poorer outcomes.

Ongoing and follow up psychiatric treatment

Depending on the severity and chronicity of the eating disorder, there may be a need for ongoing medical and psychiatry treatment. Several follow up treatment options are available to assist patients with individual, group, and family therapy to address the psychopathology of anorexia and bulimia nervosa and to aid patients during the recovery process. Adolescents should be involved in family therapy to deal with ongoing family system issues impacting their eating disorder. Research has found difficulties in initiating and sustaining cognitive behavior therapies (CBT) for patients with anorexia nervosa. However, following weight gain, application of CBT has been found to reduce risk of relapse. Conjoint family therapy and separated family therapy were equally effective in global measures of outcome in one study. However, symptom change was more marked in those receiving separated family group, whereas psychological
change was more prominent in those receiving conjoint family therapy. Those adolescents hospitalized for inpatient treatment had an equivalent extent of weight restoration when receiving family therapy as for family group psychoeducation, a less expensive form of treatment. Community and self-help groups may also be supportive as patients progress in their recovery.

Adjunctive medication shows no additional advantage to good nursing care in undernourished patients being treated in structure eating-disorder-specific programs in hospital settings. There have been studies that support use of antidepressants (fluoxetine in variable doses from 20-60 mg) found a significant advantage for active medication achieved in increasing weight and decreasing core eating disorder symptoms. For patients who are treatment resistant, studies have suggested second generation antipsychotics may improve the rate of weight gain. Medication maintenance will help patients deal with enduring psychiatric symptoms.

Nutritional rehabilitation program can help patients deal with their concerns about body image and educate them about the risks of relapse along with providing ongoing support. Nutritional supplements and addressing osteopenia and osteoporosis is necessary in treating anorexia nervosa effectively.


Why new documents?
CompCare takes its providers' comments and suggestions seriously. In an effort to increase turnaround timeliness and to lessen paperwork, while still gathering needed clinical information to appropriately manage members’ benefits and authorize outpatient services, CompCare has revised its concurrent Outpatient Treatment Review (OTR) form and its Psychological Testing Request Form. In addition, CompCare has completed its Preferred Practice Guidelines for Psychological Testing. These guidelines will assist providers in better understanding CompCare's authorization process for psychological testing.

Do I have to use the revised forms starting now?
Yes*, CompCare asks you begin using the revised OTR and Psychological Testing Request Forms immediately.

In our effort to increase turnaround time for outpatient concurrent review requests and psychological testing requests, we require all previous versions of the OTR and Psychological Testing Request Forms no longer be used after April 15, 2004.

*Connecticut providers are exempt from using the compcare revised otr form. Connecticut providers must continue to use the Connecticut state-mandated review forms. However, the Connecticut providers are requested to continue to use the fax number on this notice.

Which one of the forms do I use?
There are now two OTR forms. One is for Therapists to complete and is labeled ‘Therapy Only’. The other is for Psychiatrists or Nurse Practitioners, who provide medication management or medication management with some therapy, to complete and is labeled ‘Medication Management Only’.
In addition, doctoral level psychologists or those clinicians certified in administering psychological testing must complete the ‘Psychological Testing Request Form’ when making requests for testing.

**When do I fill out the OTR forms?**
If the member requires additional visits beyond those initially authorized by CompCare, a concurrent OTR form must be sent requesting more visits. We ask providers to complete the OTR form one week prior to the next visit and fax to CompCare using the toll-free number so that there is adequate time to process the OTR. Accredited by the National Committee for Quality Assurance (NCQA), CompCare follows the timeliness standard of fifteen (15) calendar days to receive, verify eligibility and benefits, review and reply to an OTR unless a state specifies a more stringent timeframe.

**Why revise the Psychological Testing Request Form and develop Preferred Practice Guidelines?**
The Psychological Testing Request Form was revised and expanded to include a pre-certification protocol, relevant references and an appendix of common adult, child and adolescent tests. The Preferred Practice Guidelines for Psychological Testing were developed to help our network providers understand what clinical criteria CompCare expects when a provider asks for psychological testing and what guides CompCare’s authorization process and approval.

**Where can I get copies of the new OTR and Psychological Testing Request forms?**
Feel free to make additional copies of the new OTR forms that have been included with this notice. The OTR and Psychological Testing Request forms will both be available on the CompCare website at [www.compcare.com](http://www.compcare.com) to download and print copies. The forms will be available in Adobe Acrobat format or a Word Document template for use on your computer. Additional copies are in the Provider Resource Guide or can be mailed/e-mailed to you upon your request by calling our provider line at 1(800) 458-6139.

**What is CompCare’s toll-free fax number and how do I use an extension?**
To send a fax to CompCare, *dial* the toll-free number 1 (877) 436-3604.

*FOR QUESTIONS OR ASSISTANCE, CALL COMPCARE’S PROVIDER LINE AT 1(800) 458-6139*
Routine Mental Health (MH) & Substance Abuse (SA) Outpatient Services require Pre-authorization:

- Fill in all sections completely; unclear or missing information will cause a delay in processing.
- Send in OTR timely so review, authorization and mailer notification can be completed before the next visit.
- Previous authorizations will be expired 1 day prior to new authorization effective date requested on OTR or upon the fax receipt date whichever is later.

Member Information:
Name: _____
Health Plan: _____
Health Plan ID#: _____
Other Insurance: ☐ Yes (attach copy w/OTR) ☐ No
State: _____ DOB: _____ Age: _____ M/F: _____

Previous Treatment:
☐ None or ☐ IP MH SA and/or ☐ OP MH SA
List names & dates, include hospitalizations: _____

Substance abuse: ☐ None ☐ By History and/or ☐ Current/Active
Substance(s) used, amount, frequency & last used: _____

DSM IV Axis:
I. _____
II. _____
III. _____
IV. _____
V. _____ CURRENT _____ PAST YEAR

Primary Care Physician (PCP) Communication:
Has information been shared with the PCP regarding:
• The initial evaluation & medication regime? ☐ Yes ☐ No
• Any changes in medication? ☐ N/A ☐ Yes ☐ No
• Recent psychiatric hospitalizations? ☐ N/A ☐ Yes ☐ No
PCP Name/Date last notified: _____
If No, explain: _____

Your Current Treatment: Date of initial visit: _____
Frequency of Visits: _____
# of visits requested to date: _____ # of visits used to date: _____
Your OTR Request: # of additional visits anticipated: _____
Authorization Effective Date: _____ CPT Code: _____

Provider Information:
Agency Name: _____
Practitioner Name: _____
Practitioner Licensure: _____
Telephone: (_____ ) _____ FAX: (_____ ) _____
E-Mail: _____

Treatment Focus:
List primary complaint/problem to be addressed: _____
_____
List pt’s desired outcome/realistic and achievable goal: _____
_____

a. Did you initially educate, then update the member about their psychiatric condition, medication risks and benefits and compliance? ☐ Yes ☐ No
b. Did the member participate in this treatment plan? ☐ Yes ☐ No
c. Did you include the member’s support system in a and b? ☐ Yes ☐ No ☐ N/A
d. If c is N/A or No because “no primary support available”, did you provide information or resources regarding community support? ☐ Yes ☐ No
If No to a, b, or d, explain: _____

Medications: Name of Drug/Dosage/Frequency _____

*Current Risk/Lethality:
Suicidal
☐ 1 NONE ☐ 2 LOW ☐ 3 MOD* ☐ 4 HIGH* ☐ 5 EXTREME*
Homicidal
☐ 1 NONE ☐ 2 LOW ☐ 3 MOD* ☐ 4 HIGH* ☐ 5 EXTREME*
Assault/Violent Behavior
☐ 1 NONE ☐ 2 LOW ☐ 3 MOD* ☐ 4 HIGH* ☐ 5 EXTREME*

*Overall Progress toward goal: ☐ 1 NONE* ☐ 2 MIN* ☐ 3 MOD ☐ 4 MAX ☐ 5 MET

*Compliance with treatment: ☐ 1 NONE* ☐ 2 MIN* ☐ 3 MOD ☐ 4 MAX ☐ 5 MET

Current Risk/Lethality 3-5, Progress/Compliance *1-2 checked, give intervention: _____

Provider Signature/Date: _____
Routine Mental Health (MH) & Substance Abuse (SA) Outpatient Services require Pre-authorization: • Fill in all sections completely; unclear or missing information will cause a delay in processing. • Send in OTR timely so review, authorization and mailer notification can be completed before the next visit. • Previous authorizations will be expired 1 day prior to new authorization effective date requested on OTR or upon the fax receipt date whichever is later.

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<thead>
<tr>
<th>Member Information:</th>
<th>Provider Information:</th>
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<tbody>
<tr>
<td>Name: _____</td>
<td>Agency Name: _____</td>
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<tr>
<td>Health Plan: _____</td>
<td>Practitioner Name: _____</td>
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<tr>
<td>Health Plan ID#: _____</td>
<td>Practitioner Licensure: _____</td>
</tr>
<tr>
<td>Other Insurance: [ ] Yes (attach copy w/OTR)  [ ] No</td>
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</tr>
<tr>
<td>State: _____ DOB: _____ Age: _____ M/F: _____</td>
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</tr>
<tr>
<td>Previous Treatment:</td>
<td>Telephone: (_____ ) FAX: (_____ )</td>
</tr>
<tr>
<td>[ ] None or [ ] OP MH SA and/or [ ] IP MH SA</td>
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<tr>
<td>List names &amp; dates, include hospitalizations: _____</td>
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<tr>
<td>Substance abuse: [ ] None [ ] By History and/or [ ] Current/Active</td>
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</tr>
<tr>
<td>Substance(s) used, amount, frequency &amp; last used: _____</td>
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</tr>
<tr>
<td>DSM IV Axis:</td>
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<tr>
<td>VI. _____</td>
<td></td>
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<td>VII. _____</td>
<td></td>
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<tr>
<td>VIII. _____</td>
<td></td>
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<tr>
<td>IX. _____</td>
<td></td>
</tr>
<tr>
<td>X. _____ CURRENT _____ PAST YEAR</td>
<td></td>
</tr>
</tbody>
</table>

| Primary Care Physician (PCP) Communication: |
| Has information been shared with the PCP regarding: |
| • The initial evaluation & treatment plan? [ ] Yes [ ] No |
| • This updated evaluation & treatment plan? [ ] Yes [ ] No |
| PCP Name/Date last notified: _____ |
| If No, explain: _____ |

| Your Current Treatment: | Treatment Focus: |
| Date of initial visit: _____ |
| Frequency of Visits: _____ |
| # of visits requested to date: _____ # of visits used to date: _____ |
| Your OTR Request: | List primary complaint/problem to be addressed: _____ |
| # of additional visits anticipated: _____ |
| Authorization Effective Date: _____ CPT Code: _____ |

| *Current Risk/Lethality: |
| Suicidal
| NONE [ ] 1 [ ] 2 MOD [ ] 3 [ ] 4 [ ] 5 EXTREME |
| Homicidal
| NONE [ ] 1 [ ] 2 MOD [ ] 3 [ ] 4 [ ] 5 EXTREME |
| Assault/Violent Behavior
| NONE [ ] 1 [ ] 2 MOD [ ] 3 [ ] 4 [ ] 5 EXTREME |

| *Overall Progress toward goal: |
| NONE [ ] 1 [ ] 2 MOD [ ] 3 MAX [ ] 4 MET |

| *Compliance with treatment: |
| NONE [ ] 1 [ ] 2 MOD [ ] 3 MAX [ ] 4 MET |

| Medical Psychiatric Eval done? (even if PCP providing meds) [ ] Yes [ ] No |
| Medication given by [ ] Psychiatrist [ ] PCP [ ] N/A |
| Current Risk/Lethality *3-5, Progress/Compliance *1-2 checked, give intervention: _____ |

| Provider Signature/Date: _____ |
### Section I

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Results</th>
<th>Corrective Action</th>
<th>Possible Points</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Physical Facilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building is in an accessible location with written directions</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Building is handicap accessible (including elevators)</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Adequate parking is available</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Office appearance is neat, and has quality furnishings</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Restrooms are accessible and clean</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
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<tr>
<td>Waiting and examining room space is adequate for number of providers and patients</td>
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<td>No ☐</td>
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<tr>
<td>Fire safety equipment is available</td>
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<tr>
<td>Educational material is available to members</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>For Florida Medicaid only; per Florida statute 641.511(11), prominently posted in the reception area is a notice of the addresses and toll-free telephone numbers of the AHCA Administration, the Statewide Provider and Subscriber Assistance Program and the Department of Financial Services. Notice must include that the member’s health plan grievance department address and toll-free telephone shall be provided upon request.</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>II. Medical Records</strong></td>
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</tr>
<tr>
<td>Medical records are kept confidential</td>
<td>Yes ☐</td>
<td>No ☐</td>
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<tr>
<td>There are standardized clinical forms (see medical record keeping checklist)</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>5</td>
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<tr>
<td>Medical record reviews receive a score of 80% or above*</td>
<td>Yes ☐</td>
<td>No ☐</td>
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#### IV. Appropriate signs/communication

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<tr>
<th>Requirements</th>
<th>Results</th>
<th>Corrective Action</th>
<th>Possible Points</th>
<th>Points Earned</th>
</tr>
</thead>
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<td>Office hours are posted</td>
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</tr>
<tr>
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<td>Results</td>
<td>Corrective Action</td>
<td>Possible Points</td>
<td>Points Earned</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Patient Rights &amp; Responsibilities are posted</td>
<td>Yes □ No □</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>MD’s have 24 hour, on-call arrangements for urgent/emergent care and numbers are communicated to members</td>
<td>Yes □ No □</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Therapists have a system for urgent/emergent care and this is communicated to members</td>
<td>Yes □ No □</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Communications are bilingual as indicated</td>
<td>Yes □ No □ NA □</td>
<td></td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**V. Other**

| Evidence of appropriate billing practices; i.e. no balanced billing of member. | Yes □ No □ NA □ | | 5 | |
| Results of the site visit are shared with the provider | Yes □ No □ | | Not Applicable | |

**VI. Credentialing**

<table>
<thead>
<tr>
<th>Evidence of Primary Source verification</th>
<th>Results</th>
<th>Corrective Action</th>
<th>Possible Points</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through an accredited CVO, or</td>
<td>Yes □ No □</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Performed to NCQA standards</td>
<td>Yes □ No □</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Malpractice present</td>
<td>Yes □ No □</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sanctions reviews performed monthly</td>
<td>Yes □ No □</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>NPDB verifications completed at credentialing and recredentialing</td>
<td>Yes □ No □</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Opt – out for Medicare monitored for MDs</td>
<td>Yes □ No □</td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score** **______________**
Section II

I. Billing Information:
Electronic Claim Submission Capabilities: Yes ☐ No ☐
Electronic Data Interchange Capabilities: Yes ☐ No ☐

Word Processing Software Name: 
Billing Software Name: 

II. Services Provided:
☐ Hospital Consults ☐ Crisis Evaluation ☐ Crisis Stabilization
☐ CD ☐ Individual Therapy ☐ Family/Couples Therapy
☐ Group Therapy ☐ Psychiatric ☐ EAP Assessment
☐ Intensive Outpatient ☐ Treatment for All ages

III. Hospital Admitting Privileges (MD only):
☐ Psychiatric Care ☐ Substance Abuse ☐ Children
☐ Adolescent ☐ Adult ☐ Geriatric

IV. Accessibility:
☐ Consults within 4 hours ☐ Consults within 24 hours

Number of days office is open: 

V. Clinical Orientation:

Average Number of Outpatient treatment sessions per patient:
☐ up to 5 ☐ up to 10 ☐ up to 15 ☐ up to 20 ☐ > than 20

VI. Staff Clinical Supervision:
☐ Weekly with random chart review ☐ Every other week with chart review
☐ Weekly without random chart review ☐ Monthly with random chart review
☐ Monthly without random chart review

VII. Quality Management:
Do you distribute patient satisfaction surveys? Yes ☐ No ☐
Are you willing to participate in CompCare’s outcome studies? Yes ☐ No ☐

For reviewer only: To what extent do you believe this group will indeed perform according to CompCare’s delivery standards?
☐ Very Flexible ☐ Somewhat Flexible ☐ Not Flexible

Comments:

________________________________________

________________________________________

________________________________________

________________________________________
Instructions: Please check the appropriate response related to whether the form listed below is present in the provider’s standard medical record.

<table>
<thead>
<tr>
<th>FORM</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
<th>SCORE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Demographic Page that includes patient address, employer or school, home and work numbers, emergency contacts, marital/legal status, appropriate consent forms, guardian information.</td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>2. Do all pages in the record contain full patient name or ID?</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3. All entries are dated and signed/initialed by practitioner?</td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>4. The record is legible to someone other than practitioner’s staff.</td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>5. Procedures in place to maintain confidentiality of patient specific identifiable information.</td>
<td></td>
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</tr>
<tr>
<td>6. All consults, lab results etc. are initialed by the practitioner</td>
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<tr>
<td>7. A medical and psychiatric history includes:</td>
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<td></td>
</tr>
<tr>
<td>a. Presenting problem/Chief complaint</td>
<td></td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>b. Previous treatment dates</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>c. Relevant medical conditions</td>
<td></td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>d. Allergies</td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>e. Current medications</td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>f. Substance Use/Abuse (including smoking)</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>g. Mental status exam</td>
<td></td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>h. DSMIV Diagnosis</td>
<td></td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>i. Sources of clinical data</td>
<td></td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>j. Relevant psychological and social conditions.</td>
<td></td>
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</tr>
<tr>
<td>k. Relevant family information</td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>l. Developmental history for children and adolescents</td>
<td></td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>8. Special status situations prominently noted, documented, and revised in compliance with written protocols (as appropriate)</td>
<td></td>
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<tr>
<td>9. Treatment Plan consistent with diagnosis indicates goals and time frames for attainment</td>
<td></td>
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<td></td>
<td>6</td>
</tr>
<tr>
<td>10. Follow-up/Discharge Plan Form</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>11. Release of Information for PCP</td>
<td></td>
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<td></td>
<td>8</td>
</tr>
<tr>
<td>12. Informed Consent Form – for medications</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>13. Patient rights and responsibilities (inpatient only)</td>
<td></td>
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<td></td>
<td>8</td>
</tr>
<tr>
<td>14. Problem list (outpatient only)</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>15. Release of Information Form</td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>16. Advance Directives</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Follow-up for deficiencies:

Score: ________
*A blinded treatment record or a model treatment record in place of an actual record may be used. Score is computed by dividing points earned by total available points. NA’s do not count toward the denominator or numerator.