Corporate Medical Policy

Residential Treatment

File Name: residential_treatment
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Description of Procedure or Service

A residential treatment facility is a 24-hour facility that offers treatment for individuals that require close monitoring of their behavioral and clinical activities related to their psychiatric treatment, eating disorder, or treatment for substance use disorders (alcohol and/or other substances), and is licensed under applicable state laws to provide the services for which authorization or coverage is being requested. These programs are comprehensive and address potential symptoms/behaviors. The programs incorporate psychotherapeutic treatments, medication management, and education through a multidisciplinary team approach. The treatment plan is individualized and intensive, offering individual therapy, family counseling, group therapy, and recreational activities. The program will generally offer a prolonged after-care component and facilitates peer support. The individual must meet medical necessity criteria for admission into a residential facility.

Residential treatment facilities provide direct patient care by a licensed, qualified psychiatrist or addiction medicine physician or supervised physician extender per applicable state laws. A physician or psychiatrist (or designated physician extender) should evaluate the individual within the first 24 hours. Continuous assessment of the individual's need for continued residential treatment must be made by a psychiatrist, another physician or supervised physician extender. This level of care is determined by matching the individual's status and needs to recover and regain the highest level of function to the appropriate level of care.

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

Residential settings as defined by the state of North Carolina:

Nonhospital Medical Detoxification for Individuals with Substance Abuse Disorders – a residential facility which provides medical treatment and supportive services under the supervision of a physician. This facility is designed to withdraw an individual from alcohol or other drugs and to prepare individual to enter a more extensive treatment and rehabilitation program.

Social Setting Detoxification for Substance Abuse – a residential facility which provides social support and other non-medical services to individuals who are experiencing physical withdrawal from alcohol and other drugs. Individuals receiving this service need a structured residential setting but are not in need of immediate medical services; however, back-up physician services shall be available, if indicated. The facility is designed to assist individuals in the withdrawal process and to prepare them to enter a more extensive treatment and rehabilitation program.

Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children – a professionally supervised residential facility which provides trained staff who work intensively with individuals with substance abuse disorders who provide or have the potential to provide primary care for their children.

Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders - a residential service which provides active treatment and a structured living environment for individuals with substance abuse disorders in a group setting.

Residential Treatment

Therapeutic Community – a highly structured, supervised, 24-hour residential facility designed to treat the behavioral and emotional issues of individuals to promote self-sufficiency and a crime and drug-free lifestyle.

Residential settings as defined by American Society of Addiction Medicine:

ASAM Level 3.7: Medically Monitored Intensive Inpatient Services for adults and Medically Monitored High-intensity Inpatient Services for adolescents.

ASAM Level 3.5: Clinically Managed Medium-intensity Residential Services for adolescents and Clinically Managed High-intensity Residential Services for adults.

Related Policies:
Treatment For Opioid Use Disorder in Opioid Treatment Programs (OTPs)
Substance Use Disorder Partial Hospitalization Programs
Substance Use Disorder Intensive Outpatient Programs
Psychiatric Partial Hospitalization Programs
Psychiatric Intensive Outpatient Programs

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

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

Benefits Application

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

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

When residential treatment is covered

CRITERIA FOR ADMISSION FOR SUBSTANCE USE DISORDERS

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

- It should be individualized and not consist of a standard, pre-established number of days; and
- It should be the lowest level of care where treatment can safely and effectively be provided given the severity of the individual's condition.
- Services must be provided under the supervision of a physician and must be delivered by and require the judgment of a qualified and appropriately licensed provider.

A. Severity of Need
   1. The individual has a substance-related disorder as defined by a DSM-5 diagnosis that is amenable to active behavioral health treatment.
   2. The individual has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.

3. The individual exhibits a pattern of moderately severe to severe substance use disorder identified by validated standardized rating scales to include but not limited to: DSM-5 guidelines (see Note 1), PHQ-9, GAD 7, HAM-A, HAM-D, QIDS-16, YBOCs, or MADRS when there are co-occurring mental health diagnoses such as major depressive disorder or generalized anxiety disorder (See policy guidelines).
4. There is evidence of serious risk of physical harm to self or others directly attributable and related to current abuse of substances such as medical and physical instability which would prohibit safe treatment in a less-intensive setting.
5. Withdrawal management is needed in a 24-hour setting with medical and nursing monitoring due to significant signs/symptoms of withdrawal based on objective measures (such as CIWA, COWs, etc.), or elevated risk of developing serious withdrawal, there is no current indication of severe, complicated withdrawal requiring more intensive oversight and management.
6. There is clinical evidence that the individual is not likely to respond or is not able to be managed at a less-intensive setting level of care.
7. The individual's condition is appropriate for residential treatment, as there is not a need for management in an inpatient hospital setting.

   Note 1: DSM-5 guidelines to determine how severe a substance use disorder is dependent on the number of symptoms. Two or three symptoms indicate a mild substance use disorder; four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

B. Intensity and Quality of Service
   1. The evaluation and assignment of a DSM-5 diagnosis must result from a direct behavioral health evaluation within the past 48 hours by a qualified psychiatrist or addiction medicine physician or supervised physician extender per applicable state laws. The individual has been determined to be medically and psychiatrically stable and demonstrate the cognitive and physical ability to benefit from treatment in a residential setting.
   2. The program provides medical oversight and nursing supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the indivdualto live outside of a residential setting.
   3. An individualized plan of active behavioral health treatment in the residential setting is provided. This treatment must be medically monitored, with 24-hour medical services available and onsite licensed registered nursing 24hours/day. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
   4. Treatment includes at least once-a-week psychiatric reassessments.
   5. Additionally, there is sufficient availability of medical and nursing services to manage this indivdual's ancillary co-morbid medical and mental health conditions.
   6. Treatment includes medication-assisted treatment to address cravings and relapse prevention unless medically contraindicated.

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

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

- Services must be provided under the supervision of a physician and must be delivered by and require the judgment of a qualified and appropriately licensed provider.

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

B. Intensity and Quality of Service
   1. The evaluation and assignment of a DSM-5 diagnosis must result from a direct behavioral health evaluation within the past 48 hours by a qualified psychiatrist or addiction medicine physician or supervised physician extender per applicable state laws who have expertise working with children/adolescents with mental health or substance abuse disorders. The individual has been determined to be medically and psychiatrically stable and demonstrate the cognitive and physical ability to benefit from treatment in a residential setting.
   2. The program provides medical oversight and nursing supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a residential setting.
   3. An individualized plan of active behavioral health treatment in the residential setting is provided. This treatment must be medically monitored, with 24-hour medical services available and onsite licensed registered nursing 24hours/day. This plan must include:
      a) Weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, **and**
      b) Psychotropic medications, when used, are to be used with specific target symptoms identified, **and**
      c) Evaluation for current medical problems or ongoing medical services to evaluate and manage co-morbid medical conditions, **and**
      d) Evaluation for concomitant substance use issues, **and**
      e) Integrated treatment, rehabilitation and support provided by a multidisciplinary team, **and**
      f) Linkage and/or coordination with the individual's community resources with the goal of returning the individual to their regular social environment as soon as possible, unless contraindicated. For children/adolescents, school contact should address Individualized Educational Plan/s as appropriate. **and**
   4. Treatment includes at least once-a-week psychiatric reassessments, if indicated.
   5. Treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contra-indicated.

CRITERIA FOR CONTINUED STAY FOR SUBSTANCE USE DISORDERS:

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

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

B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion "A", and the individual's progress is documented by the provider at least 3 times per week. This plan receives regular reviews and revisions that include ongoing plans for timely access to treatment resources that will meet the individual's post-residential treatment needs.

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

CRITERIA FOR ADMISSION FOR RESIDENTIAL TREATMENT FOR BEHAVIORAL HEALTH CONDITIONS

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

- It should be individualized and not consist of a standard, pre-established number of days; and
- It should be the lowest level of care where treatment can safely and effectively be provided given the severity of the individual's condition.
- Services must be provided under the supervision of qualified psychiatrist or supervised physician extender per applicable state laws and must be delivered by and require the judgment of a qualified and appropriately licensed provider with expertise in treating mental health and substance use disorders.

A. Severity of Need
   1. There is clinical evidence that the individual has a DSM-5 disorder with moderately severe to severe symptoms identified by validated standardized rating scales (to include but not limited to: PHQ-9, GAD 7, HAM-A, HAM-D, QIDS-16, YBOCs, MADRS. See policy guidelines,) that is amenable to active psychiatric treatment, AND
   2. Either:
      a. There is clinical evidence that the individual would be at serious risk to self or others if he or she were not in a residential treatment program, ***or***
      b. As a result of the individual's behavioral health disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, AND
   3. The individual requires treatment in a medically supervised setting seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential setting, AND
   4. The individual's current living environment does not provide the support and access to therapeutic services needed, AND
   5. There is clinical evidence that the individual is not likely to respond or is not able to be managed at a less-intensive setting level of care.
   6. The individual is medically stable and does not require the 24-hour medical/nursing management or procedures provided in a hospital level of care.

B. Intensity and Quality of Service
   1. The evaluation and assignment of a DSM-5 diagnosis must result from a direct behavioral health evaluation within the past 48 hours by a qualified psychiatrist or supervised physician extender per applicable state laws. The individual has been determined to be medically and psychiatrically stable and demonstrate the cognitive and physical ability to benefit from treatment in a residential setting. With the geriatric individual, measurement of cognitive functioning is warranted as part of the mental status testing assessment, AND

2. The program provides medical oversight and nursing supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a residential setting, AND
3. An individualized plan of active behavioral health treatment in the residential setting is provided. This treatment must be medically monitored, with 24-hour medical services available and onsite licensed registered nursing 24 hours/day. This plan must include:
    a. Weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, AND
    b. Psychotropic medications, when used, are to be used with specific target symptoms identified, AND
    c. Evaluation for current medical problems or ongoing medical services to evaluate and manage co-morbid medical conditions, AND
    d. Evaluation for concomitant substance use issues, AND
    e. Integrated treatment, rehabilitation and support provided by a multidisciplinary team, AND
    f. Linkage and/or coordination with the individual's community resources with the goal of returning the individual to their regular social environment as soon as possible, unless contraindicated.

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

- It should be individualized and not consist of a standard, pre-established number of days; and
- It should be the lowest level of care where treatment can safely and effectively be provided given the severity of the individual's condition.
- Services must be provided under the supervision of a physician and must be delivered by and require the judgment of a qualified and appropriately licensed provider.

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

B. Intensity and Quality of Service
    1. The evaluation and assignment of a DSM-5 diagnosis must result from a direct behavioral health evaluation within the past 48 hours by a qualified psychiatrist or supervised physician extender per applicable state laws. The individual has been determined to be medically and psychiatrically stable and demonstrate the cognitive and physical ability to benefit from treatment in a residential setting, AND
    2. The program provides medical oversight and nursing supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a residential setting, AND
    3. An individualized plan of active behavioral health treatment in the residential setting is provided. This treatment must be medically monitored, with 24-hour medical services available and onsite licensed registered nursing 24 hours/day. This plan must include:
        a. Weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, AND
        b. Psychotropic medications, when used, are to be used with specific target symptoms identified, AND

c. Evaluation for current medical problems or ongoing medical services to evaluate and manage co-morbid medical conditions, AND
d. Evaluation for concomitant substance use issues, AND
e. Integrated treatment, rehabilitation and support provided by a multidisciplinary team, AND
f. Linkage and/or coordination with the individual's community resources with the goal of returning the individual to their regular social environment as soon as possible, unless contraindicated. For children/adolescents, school contact should address individualized educational plan/s as appropriate.

CRITERIA FOR CONTINUED STAY FOR RESIDENTIAL TREATMENT FOR BEHAVIORAL HEALTH CONDITIONS

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
   1. The persistence of symptoms that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), ***or***
   2. The emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), ***or***
   3. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the individual can return to a new or previous living situation, AND
B. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed, AND
C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the individual's ability to return to a less-intensive level of care, AND
D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion A, and this is documented in weekly progress notes, written and signed by the provider, AND
E. There is evidence of weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, AND
F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources, AND
G. All applicable elements in Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

When residential treatment is not covered

1. Residential treatment is not covered if the facility is not licensed under applicable state laws to provide the services for which authorization or coverage is being requested.
2. Residential treatment is not covered if services are not delivered by a qualified and appropriately licensed provider and supervised by a physician.
3. Residential treatment is not covered for the use of foster homes, group homes, boarding schools, or halfway houses, or other sober living environments.
4. Residential treatment is not covered for Wilderness Training Centers or camps.
5. No benefits are available for custodial care.
6. Residential treatment is considered not medically necessary when the above criteria for admission or continued stay (Substance Abuse Disorders or Residential Treatment for Behavioral Health Conditions) are not met.
7. Residential treatment is not covered for Nonhospital Medical Detoxification for individuals with substance abuse disorders.

Policy Guidelines

Admission to a residential facility requires precertification, prior plan approval, or prior authorization.

Depressive disorders can be diagnosed and assessed using standardized rating scales that accurately measure depressive symptoms. The Beck Depression Inventory (BDI), the Hamilton Depression Rating Scale (HDRS), the Patient Health Questionnaire-9 (PHQ-9), the Montgomery-Asberg Depression Rating Scale (MADRS), and the Geriatric Depression Scale (GDS) are some of the scales used for adults and older adults.

The tools for assessing depression in young people include the BDI, the Children's Depression Inventory (CDI), and the PHQ-9 modified for adolescents (PHQ-A).

Depression Assessment Instruments

The Hamilton Rating Scale for Depression (HAM-D24) is a 17-item rating scale to determine the severity level of depression in a patient before, during, and after treatment. The total score ranges from 0 to 52, with the score corresponding to the following classifications: · 0-7: No depression (normal) · 8-16: Mild depression · 17-23: Moderate depression · ≥24: Severe depression

Montgomery-Asberg Depression Rating Scale (MADRS), an adaptation of the HAM-D, is a 10-item scale with each item rated on a 0-6-point scale. MADRS investigates the presence of affective, somatic, cognitive and behavioral symptoms of depression. MADRS has as a greater sensitivity to change in symptoms over time. The total score classifies the patient's level of severity of depression as normal or absent 0–6; mild 7–19; moderate 20–34; severe 35–60.

Patient Health Questionnaire 9 (PHQ-9) relies on patient self-report. There are nine questions based on the nine DSM-IV depression diagnostic criteria, and scores are based on frequency of symptoms. The possible range is 0-27, with minimal depression 0-4, mild 5-9, moderate 10-14, moderately severe 15-19, and severe 20-27.

In addition to screening, rating scales are frequently used during treatment to assess changes in symptoms. A roughly 50% reduction in scores on the BDI, HDRS, PHQ-9/PHQ-A, or the MADRS has been deemed clinically significant.

Billing/Coding/Physician Documentation Information

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

Applicable service codes: *H0010, H0011, H0017, H0018*

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

Scientific Background and Reference Sources

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 1998

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

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

Medical Policy Advisory Group - August 12, 1999

Specialty Matched Consultant Advisory Panel - 9/2000

Medical Policy Advisory Group - 10/2000

Specialty Matched Consultant Advisory Panel - 9/2002

Specialty Matched Consultant Advisory Panel - 8/2004

Specialty Matched Consultant Advisory Panel - 8/2006

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

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 2014

Specialty Matched Consultant Advisory Panel – 7/2014

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 2015

Specialty Matched Consultant Advisory Panel – 7/2015

Medical Necessity Criteria from Magellan Behavioral Health, Inc. 2022

ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update
ASAM Clinical Practice Guideline on Alcohol Withdrawal Management 23, 2020

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th edition).

American Psychological Association. (n.d.). Depression Assessment Instruments. American Psychological Association. https://www.apa.org/depression-guideline/assessment/

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American Society of Addiction Medicine. (2023). The ASAM Criteria, Fourth Edition. ASAM Criteria and Levels of Care. https://discover.hazeldenbettyford.org/

Medical Director review 3/2024

Medical Director review 6/2024

Specialty Matched Consultant Advisory Panel Review 6/2024

Policy Implementation/Update Information

7/99	Local Policy issued.
8/99	Medical Policy Advisory Group reaffirmed
8/99	Reformatted, Medical Term Definitions added.
10/00	Specialty Matched Consultant Advisory Group review. No change recommended in criteria. System coding changes. Medical Policy Advisory Group review. No change in criteria. Approve.
2/02	Formatting change.
11/02	Specialty Matched Consultant Advisory Panel review 9/2002. No changes.
8/26/04	Specialty Matched Consultant Advisory Panel review 8/4/2004. Revised Description of Procedure or Service section. No changes to criteria. Updated Benefit Application, Policy Guidelines, and Billing/Coding sections for consistency. References added.
9/23/04	Updated Last Review Date and Next Review Date.
8/28/06	Specialty Matched Consultant Advisory Panel review 8/1/2006. No changes to policy statement. Policy status changed to: "Active policy, no longer scheduled for routine literature review". References added. (btw)
6/22/10	Policy Number(s) removed (amw)
8/7/12	Specialty Matched Consultant Advisory Panel review 7/18/12. No changes to policy statement. Policy returned to Active status. (sk)
3/11/14	Specialty Matched Consultant Advisory Panel review 7/17/13. No changes to policy statement. References added. (sk)
11/11/14	Specialty Matched Consultant Advisory Panel review 7/29/14. Added admission criteria and continued stay criteria for Psychiatric Residential Treatment and Eating Disorders Residential Treatment. Reference added. Clarified that Residential Treatment is not covered unless criteria are met. Title changed to Residential Treatment. Medical Director review. (sk)
9/1/15	Specialty Matched Consultant Advisory Panel review 7/29/15. Reference added. (sk)
8/30/16	Criteria for admission and continued stay in residential treatment for chemical dependency extensively revised for clarity. Specialty Matched Consultant Advisory Panel review 7/27/2016. Policy intent unchanged. (an)
7/28/17	Specialty Matched Consultant Advisory Panel review 6/28/2017. No change to policy statement. (an)
7/27/18	Specialty Matched Consultant Advisory Panel review 6/27/2018. No change to policy statement. (an)
7/30/19	Specialty Matched Consultant Advisory Panel review 7/10/2019. No change to policy statement. (eel)
12/31/19	Policy archived effective 1/1/2020. (eel)
4/1/2024	Reinstated medical policy. Updated definition of residential treatment to include “is licensed under applicable state laws to provide the services for which authorization or coverage is being requested.” Updated related policies. Updated coverage criteria, description, and references

based on updated literature and current standards of care. Medical director review 3/2024. **Notification given 4/1/2024 for effective date 7/1/2024**. (tt)

7/17/24 Specialty Matched Consultant Advisory Panel Review 6/2024. References added. No change to policy statement. Medical Director review 6/2024. (tt)