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Behavioral Health Residential Treatment Centers

Substance Abuse Disorders and Mental Health

Audience
Providers, Members, Brokers, MHC

Purpose

Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time

Definition

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

There is a wide range of public and private-sector residential programs for behavioral health conditions, including residential care for adults with serious behavioral health disorders combined with substance abuse. All provide 24-hour supervision and a drug- and alcohol-free environment, along with professional or peer support. Residential care addresses the aspects

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

The American Society of Addiction Medicine (ASAM) Levels of CARE1
The ASAM Criteria describes SUD treatments based on four broad levels of care: (1) Outpatient services, (2) Intensive Outpatient/Partial Hospitalization Services, (3) Residential/Inpatient Services, and (4) Medially Managed Intensive Inpatient Services. The following definitions pertain to this policy:

ASAM Level 3.5: Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults. This level of care provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Patients at this level can tolerate and use a full active milieu or therapeutic communities. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

ASAM Level 3.7: Medically Monitored High-Intensity Inpatient Services for adolescents and Medically Monitored Intensive Inpatient Services Withdrawal Management for adults. This level of care provides 24-hour nursing care with a physician's availability for significant problems in Dimensions 1, 2, or 3. Patients at this level of care require medication and have a recent history of withdrawal management at a less intensive level of care, marked by past and current inability to complete withdrawal management and enter continuing addiction treatment. This is the appropriate setting for patients with subacute biomedical and emotional, behavioral, or cognitive problems that are so severe that they require inpatient treatment. Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.

Policy/Procedure

Mountain Health Co-Op covers services provided in a behavioral health residential treatment center when the member and facility meet minimum standards.
Prior Authorization Timeline:

- Prior authorization for the Behavioral Health Residential Facility must be determined before admission. Failure to obtain authorization may result in claim denial.
- If a member is being directly admitted to an RTC, a referral from an outpatient contracting provider (see criteria below) must be submitted to be considered a valid

prior authorization. A referral from the submission of RTC is not valid. If the member is being stepped down from another level of care, the referral may be from the admitting facility.

If a member is stepping down within the same facility or transferring to a new facility for a lower level of care after successfully completing a higher level, no external referral is required. Referrals are only necessary for new admissions to the facility.

• A current DSM diagnosis must be consistent with the most current DSM volume diagnosis, which reflects the symptoms and behaviors that precipitate the request for residential treatment.

1. **Staffing Requirement for Admission**

   1.1 Facility Director: The Facility Director must possess appropriate academic credentials and administrative experience in adult, child, and adolescent psychiatric, substance abuse, and eating disorder treatment. The Facility Director is typically responsible for the fiscal and administrative support of the facility's clinical program.

   1.2 Medical Director: The facility must be overseen by a Board-Certified Medical Director (MD/DO/Ph.D.) in the area in which the facility treats patients, such as substance abuse disorder (SUD) or mental health. The Medical Director is responsible for coordinating medical services and directing member treatment. The Medical Director must be a board-eligible or board-certified psychiatrist (experienced in adult, child, and adolescent psychiatry, substance abuse, or eating disorders, depending on the facility's services) or a psychiatrist who has successfully completed an approved residency in the line of services the facility provides.

   1.3 Clinical Director: The Clinical Director is responsible for coordinating clinical services and implementing patient treatment. The clinical director must be a board eligible or board certified psychiatrist (experienced in adult, child, adolescent psychiatry, substance abuse or eating disorders depending of facility services), or a psychiatrist who has successfully completed an approved residency in the line of services the facility treats, a psychiatric mental health nurse practitioner (PMHNP)/advanced practice registered nurse (APRN) who is experienced in mental health treatment.

2. **Intensity of Services**

   2.1 Level II residential behavioral health services will be provided in a state-licensed facility that provides a structured treatment setting with 24-hour supervision, counseling, and other therapeutic activities for persons who do not require on-site medical services. Behavioral health professionals are to be available on-site and on-call and provide continuous treatment to members experiencing a behavioral health issue that limits their independence, but who can participate in all aspects of treatment and meet physical and age-appropriate needs.

   2.2 Treatment should be at the least restrictive level of care consistent with needs. It should not be instituted unless there is documentation of a failure to respond to or a

professional judgment of an inability to be safely managed at a less restrictive level of care.

3. **Prior Authorization Turnaround Times**
   Mountain Health Co-Op follows standard and expedited NCQA turnaround times.

   3.1 Reauthorizations: Reauthorizations must be submitted at least seven days before the current authorization expires, accompanied by the following documentation:
   3.1 an updated treatment plan, a
   3.2 a detailed discharge plan,
   3.3 a weekly clinical summary with an updated treatment plan
   3.4 documentation demonstrating the member continues to be actively engaged in all aspects of the treatment
   Length of authorization: Up to 60 days maximum

4. **Expected Response**
   4.1 Active treatment with the services available at this level of care can reasonably be expected to improve the patient's condition, allowing for their discharge from the residential treatment facility as soon as possible and facilitating their return to outpatient care and/or family living. Residential treatment is not a long-term treatment phase and typically lasts no longer than 60 days. Treatment longer than 60 days at this phase is on a case-by-case basis. Active, progressive treatment and movement through the behavioral health treatment phase are expected.

5. **Types of Therapies**

5.1 Individual therapy is the treatment of psychological problems that is conducted on a one-to-one basis. One therapist sees one client or member at a time, tailoring the process to their unique needs to explore contributory factors and alleviate symptoms. Also known as dyadic therapy or individual psychotherapy.

5.2 Group therapy is psychotherapy conducted by a mental health therapist with at least two and no more than twelve members simultaneously. Groups of more than 12 participants are permitted when a co-leader assists the primary therapist. Group co-leaders are not required to hold a master's degree in therapy. Possible group options include anger management, conflict resolution, social skills training, and self-esteem management.

5.3 Milieu Therapy is a psychotherapeutic treatment based on the modification or manipulation of the client's life circumstances or immediate environment. Milieu therapy aims to organize the social and physical environment in which the client lives or is being treated to promote healthier, more adaptive cognition, emotions, and behavior.

6. **Contraindications for admission**
   6.1 Running away and disobedience are not in and of themselves sufficient reasons for admission to residential level of care.

6.2 Readmission or continued stay is expected to be counter-therapeutic due to 1 or more of the following:

- **a.** Previous admissions to the same or a similar program have not been therapeutically beneficial;
- **b.** The patient has reached maximum expected therapeutic benefit from previous admissions or during the current admission;
- **c.** The treatment reinforces an unhealthy self-image or identification with the illness.
- **d.** For a patient with attachment disorder, residential treatment would interfere with interventions that are more appropriate to take place in the home environment.

7. Admission Criteria: (Must meet all 7.1 AND 7.2 criteria)

Behavioral and Functioning

As a result of a DSM-V diagnosis, the member has a significant risk of harm to self or others or disturbance of mood and thought behavior, which renders the member incapable of developmentally appropriate self-care or self-regulation, as evidenced by:

7.1 - Risk Behaviors: Significant risk or harm within the past 3 months, as evidenced by

- **a.** Significant suicidal, aggressive, self-harm, or homicidal thoughts or behaviors; OR
- **b.** Significant impulsiveness with poor judgment, insight, and apparent and persistent inability of environmental supports to safely maintain the individual despite adequate intensive outpatient service; OR
- **c.** Risk of physiological jeopardy that threatens health and functioning, such as significant weight
- **d.** Changes, chronically disrupted sleep, medication side effects, or toxicity due to a psychiatric condition; OR
- **e.** Risk of significant physical or sexual acting out behavior with poor judgment and insight. **AND**

7.2 Serious functional impairment of self-care or self-regulation as evidenced by the documentation of psychiatric symptoms that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.

8. All of the following intensity of services must be met (8.1-8.19)

8.1 Accredited by and remain current and in good standing with one of the following organizations: JACHO, CARF, ASAM, or another body approved by MHC.

8.2 Referral and admission orders to an in-network RTC are made by a licensed provider (e.g., MD/DO, DNP, APRN, Ph.D., LCSW, LAC) practicing in behavioral health. The referral and order must be from an in-network practicing behavioral health provider with Mountain Health CO-OP and cannot be from the admitting facility. The referring

provider must have assessed the member face-to-face within 14 calendar days preceding the referral/admission. A referral from the RTC is invalid for these purposes; and

8.3 For contracting residential treatment facilities only

- **a.** Mountain Health Co-Op acknowledges the limited availability of behavioral health providers in Montana and Idaho and does not intend for referral requirements to create unnecessary delays in access to care.
- **b.** Admission to a care facility requires prior clinical assessment and documented coordination by a primary care provider or qualified outpatient behavioral health professional. Self-admission without such assessment and coordination is not permitted. Referrals may be accepted from contracted licensed practitioners, including those with professional affiliations at the admitting facility, provided the referral reflects independent clinical judgment and appropriate coordination of care.

8.4 The facility is licensed by the appropriate state agency

8.5 The facility and program must be overseen by a board-certified or board-eligible medical director in Psychiatry who provides onsite psychiatric evaluations and treatments with evidence-based medication management.

8.6 There is an expectation that the member's history and physical examination are completed within 24 hours of admission

8.7 There is an expectation that drug screens and relevant lab tests are completed upon admission and only as clinically indicated and are documented in the medical record.

8.8 The attending provider is a psychiatrist, a licensed psychiatric nurse practitioner, or a physician assistant with a formal practice agreement with a psychiatrist (when permitted by state laws) who is responsible for diagnostic evaluation within 48 hours of admission. Following the initial diagnostic evaluation, the physician or physician extender is expected to provide documentation, monitoring, and evaluation at least weekly. The Attending Provider must be available 24 hours per day, 7 days per week.

8.9 There is an expectation that a Physician visit occurs weekly or more frequently if clinically indicated.

8.10 There is an expectation that, within 72 hours of admission, following a multidisciplinary assessment that includes input from recent treating providers, an individualized treatment plan (ITP) is developed and documented in the medical record. The ITP should use evidence-based concepts and be revised as necessary to reflect changes in the individual's clinical condition. The ITP should include, but is not limited to, identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, need for supportive living placement to continue recovery, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure. conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that may affect the likelihood of successful community transition

8.11 Treatment programming includes an expectation of at least one individual counseling session per week, or more as clinically indicated, which is documented in the medical record.

8.12 There is an expectation that evaluations of the member are performed daily by a licensed behavioral health provider and are documented in the medical record.

8.13 Treatment programming is multidisciplinary and includes daily clinical services that comprehensively address the needs identified in the member's treatment plan.

8.14 Mental health and medical services are available on-site or off-site by arrangement and approval from the health plan, 24 hours a day, 7 days a week.

8.15 Documentation of daily evaluations must be available for review until discharge.

8.16 The Medical Director or other physician must be available 24 hours a day, seven days a week

8.17 On-site nursing (RN's) are on-site with a minimum of 8 hours a day, 7 days a week. RNs are available 24 hours a day and respond to significant clinical events within one hour.

8.18 Provide 24-hour, seven-day-a-week nursing services; have an interdisciplinary staff consisting of social workers, nurses, counselors, and behavioral health specialists clinically trained to assess and treat the patient's condition with specialized training in behavior management techniques.

8.19 Time-based, measurable goals drive the treatment plan

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9. All of the following criteria 9.1-9.12 must be met

9.1 The member does not meet the criteria for inpatient mental health treatment.

9.2 The member is medically stable.

9.3 The member has been given a severe mental health diagnosis according to the most recent DSM criteria, which will be the primary focus of daily active treatment.

9.4 The member cannot be treated safely and effectively at a lower level of care due to one (1) or more of the following

- **a.** Serious and persistent psychological impairments that have failed to respond to treatment at all appropriate levels of care, or documentation of why such treatments are reasonably expected to be insufficient to meet the member's needs. (Note. Non-participation does not constitute failure at a lower standard of care.)
- **b.** Danger to self or others.
- **c.** Profound role failure

9.5 The member can function independently and actively participate in group and individual therapy.

9.6 There is a reasonable expectation that treatment at this level of care will have a meaningful impact on the presenting symptoms and behaviors that led to the admission.

9.7 The treatment is not primarily for the convenience of the provider or member (e.g., primarily for lack of housing options, member or family healthcare respite care, or custodial needs).

9.8 The member has a significant functional impairment in more than one area that requires 24-hour monitoring and intervention, including home, School/Work, Health/Medical, and maintaining safe behaviors towards self or others.

9.9 Treatment could not be effectively provided at a lower level of care (supported by clinical documentation), or the member's home environment is not conducive to treatment or recovery, such that treatment at a lower level of care is unlikely to be successful, or no safe lower level of care is available.

9.10 The family members and/or support system are committed to change through participation in the treatment process as appropriate.

9.11 Therapy requirements must meet **ALL** the following:

- **a.** A minimum of 4 hours of therapy daily, which may include group, individual, milieu, and behavioral management, AND
- **b.** Individual Therapy at a minimum of once weekly, AND
- **c.** Family Therapy:
  - **i.** For adults, A minimum of weekly family therapy sessions.
  - **ii.** For Children: A minimum of twice weekly
- **d.** Structured therapeutic program of at least 8 hours a day, 5 days a week, AND
- **e.** Occupational, speech, and physical therapy as indicated. Services must be provided by credentialed OTR, PT, and SLT.
- **f.** The Program provides for the mental and physical health needs of the individual member, AND
- **g.** The facility is open 7 days a week. 24-hour supervision and monitoring. This includes both of the following:

  i. An on-site nurse available 24/7 who is able to provide psychiatric nursing services (e.g., observation, crisis intervention, medication administration); and

  ii. A psychiatrist is available 24/7 (at least by phone) to assist with crisis intervention, treat medical and psychiatric issues, and prescribe medication. AND

9.12 Treatment is focused on stabilization, functional improvement, and reintegration of the member.

10. This includes ALL of the following:

The residential treatment program is transitional in nature, designed with the purpose of reintegrating the individual with continued treatment services at less restrictive levels of care; and

10.1 The residential treatment program is not based on a preset number of days, **AND**

10.2 Admission to or continued stay in a residential treatment program is not primarily for custodial reasons, such as housing, but is based on active treatment of current clinical presentations

11. Documentation supports the continued stay in a Psychiatric Residential Treatment (RTC) program provided under the Supervision of an attending psychiatrist or psychiatric extender may be indicated when all of the following are met.

(11.1. – 11.2.) must be met:

11.1 The member continues to meet the admission criteria

11.2 Documentation supports that a physician or a physician extender provides daily medical management and evaluation services.

11.3 There is a reasonable expectation that continued treatment provided at this level of care will produce improvement that is sustainable after discharge.

11.4 The family is involved in the treatment and discharge planning process.

11.5 The member continues to demonstrate motivation for change, interest in, and ability to actively engage in their behavioral health treatment, as evidenced by active participation in groups, cooperation with the treatment plan, actively working on assignments, developing a discharge plan, and other indicators of treatment engagement.

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

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

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

11.9 Evidence should demonstrate weekly support system involvement unless there is a clinically appropriate and documented reason.

11.10 Family participation (see Policy Guidelines):

a. For Adults: Family treatment is encouraged when clinically appropriate. Family treatment is available and can be provided at an appropriate frequency when clinically warranted.

b. For Children/adolescents: Family treatment is provided at a minimum of once a week or more often if clinically indicated. If family treatment is not provided, the facility/provider specifically lists the contraindications to Family Therapy. The family/support system assessment will be completed within 72 hours of admission, with the expectation that the family will be involved in treatment decisions and discharge planning throughout the care process.

11.11 For both Adults and Children:

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

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

12. Discharge criteria

Termination of continued authorization is indicated by 1 or more of the following:

12.1 Treatment goals appropriate to the residential level of care have been met.

12.2 The patient's condition has improved to the point where the patient no longer requires 24 hours per day supervision and observation.

12.3 The patient can be safely and effectively treated at a lower level of care (e.g., mental health, partial hospitalization, intensive outpatient or outpatient treatment).

12.4 The patient's physical condition necessitates transfer to a medical facility.

12.5 The patient is not making reasonable progress at the current setting or level of care (unless a recent treatment plan change is reasonably expected to resolve the lack of progress).

12.6 Nonparticipation in therapies, program

12.7 If the patient or family declines an available appropriate lower level of care, or if the residential facility fails to engage in reasonable and appropriate discharge planning.

13. Residential Treatment Center Exclusions

Certain services provided within an RTC may provide learning and growth opportunities to members; however, services that are not founded on evidence-based research, as determined by MHC, or otherwise do not meet the criteria of the member's benefit design will be considered an exclusion of the member's contract. Additional requirements for medical necessity and similar limitations also apply.

Examples of services that are not evidence-based and are not a covered benefit are listed below: **(not all inclusive)**

13.1 Wilderness Programs, Boot Camps, and/or Outward-Bound Programs:

At times, state statute defines 'boot camps' or 'wilderness therapy programs' as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most 'boot camps' and 'wilderness programs' do not use a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child's care. Also, the Joint Commission nearly universally denies certification to programs that fail to meet the quality-of-care guidelines for medically supervised care provided by licensed mental health professionals.

13.2 Therapeutic Group Homes:

Professionally directed living facilities with behavioral health consultation available as needed. Group homes serve a broad, varied patient population with significant individual and/or family dysfunction.

13.3 Therapeutic Day Schools:

Designed for students who struggle in a standard academic setting and who may have fallen behind due to emotional, behavioral, or other psychological challenges. Some are boarding schools, and others are schools where students are on campus only to attend classes during the day.

13.4 Therapeutic Boarding Schools:

The primary purpose of these facilities is to provide specialized educational programs that may also be supplemented by psychological and psychiatric services. These facilities may serve diverse student populations, many of whom also have difficulties in social and academic areas. These programs generally do not have specialized nurses

on-site and/or a psychiatrist available to assist with medical issues/crisis intervention, and medication administration as needed. These facilities are generally for long-term stays without clear goals for returning to the community and home. Often advertised as residential treatment centers without the core foundation.

13.5 Community Alternatives:

The admission is used for purposes of convenience or as an alternative to incarceration, or simply as respite or housing

13.6 Environmental Admissions:

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

13.7 Custodial Care:

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

Noncovered Services

13.8 Any facility considered/described to be a luxury facility is not a covered service

13.9 Any facility that describes itself as a luxury rehab facility or retreat.

13.10 Facility may include therapy services such as acupuncture, art therapy, cooking, sports, equine, beaches, spas/massage.

13.11 Meals, self-administered medications, and transportation.

13.12 Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature.

13.13 Outpatient psychiatric day treatment programs that consist entirely of activity therapies.

13.14 Daycare programs, which include, but are not limited to, those that provide primarily social, recreational, or diversional activities, custodial, or respite care.

13.15 Psychosocial programs that are primarily for social or recreational purposes.

13.16 Vocational training when the services are related solely to specific employment opportunities, work skills, or work settings.

13.17 Therapies not based on American Psychiatric and American Psychological Association acceptable techniques and theories

13.18 Vocational or religious counseling

13.19 Consciousness raising

13.20 Testing or treatment for learning disabilities

13.21 Activities primarily for educational purposes

13.22 Marriage counseling

13.23 Services for social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of mental illness

13.24 Assertiveness training
13.25 Cognitive training
13.26 Primal therapy
13.27 Bioenergetic therapy
13.28 Obesity control therapy
13.29 Sleep therapy
13.30 Dance therapy
13.31 Music or art therapy
13.32 IQ testing, except as a component of individualized, medically necessary psychological/neuropsychological evaluation
13.33 Socialization, delinquency or custodial care services
13.34 Stress reduction classes
13.35 Pastoral counseling
13.36 Acupuncture, acupressure, massage therapy, Rolfing®, homeopathic or naturopathic remedies
13.37 Self-care or self-help training
13.38 Inpatient confinement for environmental change or similar treatment
13.39 Dream therapy
13.40 Recreational therapy
13.41 Equine or other animal therapy
13.42 Wilderness programs
13.43 Adventure therapy
13.44 Bright light therapy
13.45 Any other techniques that are not supported by scientific evidence and the medical necessity criteria.

14. It is not reasonable and necessary to provide RTC services to the following types of patients:

14.1 Members who cannot or refuse to participate (due to their behavioral, cognitive, or emotional status, e.g., individuals with persistent substance abuse, moderate to severe intellectual disability, or organic brain syndrome) with active treatment of their mental disorder, or who cannot tolerate the intensity of a RTC program.

14.2 Members who require primarily social, custodial, recreational, or respite care. Members with multiple absences or who are persistently non-compliant.

14.3 Members who do not participate in active treatment.

14.4 Members whose plan of care does not support the need for active treatment.

14.5 Court-ordered care.

15. Clinical Rationale

15.1 Behavioral Health Residential Treatment Centers (BHRTC) are live-in facilities providing therapy for substance abuse, mental illness, or other behavioral problems. These are less intensive than inpatient facilities such as hospitals, but the treatment is longer. Their home-like atmosphere may help patients build self-esteem, develop relationships, and improve skills. At the same time, patients

benefit from intensive, professional treatment delivered daily on-site. Treatment can include individual psychotherapy, group therapy, vocational/educational counseling and support, and treatment for co-occurring addictions. Because clinicians treat patients where they live, they see the full picture of a patient's functioning and use that perspective and insight to fine-tune therapy.

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

15.3 In a study on obsessive-compulsive disorder (OCD), Steward et al. identified consecutive intensive residential treatment (IRT) subjects that were ascertained over a 12-month period (female n =26, male n =35). Psychometric measures were completed at admission and discharge from the McLean/MGH OCD Institute IRT, including the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), Beck Depression Inventory (BDI), and the Work and Social Adjustment Scale (WSA) (n = 61). These measures were repeated at 1 (n = 57), 3 (n = 42), and 6 months (n = 36) following discharge. This study was IRB-approved. Obsessive-compulsive disorder means severity did not significantly worsen from discharge to the 1 (17.4, SD 6.5), 3

15.4 (16.5, SD 7.4), or 6 months (16.2, SD 7.3) follow-up ($p > 0.25$). Furthermore, a significant improvement from admission was maintained at each of the 1 (17.4, SD 6.5), 3 (16.5, SD 7.4), and 6-month (16.2, SD 7.3) follow-up time points ($p < .001$). Relapses were significantly more likely to be living alone following discharge ($p = 0.01$) and were less likely to have comorbid illnesses ($p = 0.02$). No significant differences were found between study dropouts and completers concerning YBOCS scores ($p > 0.47$). In the first OCD IRT long-term follow-up study, findings indicated that mean treatment gains were maintained at 1, 3, and 6 months post-discharge. This finding is important as it suggests that improvements of OCD severity were subsequently retained in home and work environments. Improvement of depression severity from admission was also maintained.

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

15.6 Concerning the reasonable proximity of residential treatment to a member's community or residence and support system, SAMSHA and other organizations have noted that outcomes are improved when residential care is provided near the patient's home. In the Guidelines published in 2009 outlining the guiding principles and core elements of recovery-oriented care, SAMSHA, in combination with treatment and recovery support services, can enable individuals to build a life that supports recovery as they work to control symptoms through traditional treatments or peer support groups. These types of services support the goals of community integration and social inclusion for people with mental and/or substance use disorders and their families. SAMHSA also encourages the use of peer support services, or services designed and delivered by people who have experienced a mental and/or substance use disorder and are in recovery.

Applicable Codes

Revenue Codes

1001	Residential treatment, psychiatric (mental health)
1002	Residential treatment, chemical dependency (substance use disorders)

CPT Codes

No applicable codes

HCPCS Codes

H0010	Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0012	Alcohol and/or drug services; subacute detoxification (residential addiction program outpatient)
H0013	Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H2013	Psychiatric health facility service, per diem
H2036	Alcohol and/or other drug treatment program, per diem
T2048	Behavioral health; long-term residential care (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem

Payment is subject to the provider's contract for in-network or out-of-network reimbursement, including member benefits at the time of eligibility.

Per-diem is an all-inclusive allowance for facility and services, such as room and board,

pharmaceuticals, routine nursing, individual and group therapy, urine drug screening, ancillary services, psychological testing and assessment, overhead, supplies, and other similar services. Per diem payments will not be allowed for leave days on which treatment is not provided

Vendors

- **Personify**
- **HPS**

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Review/Revision/Approval History

Date	Description
02/23/2026	**Approved by policy committee**
03/9/2026	**Revised by Mountain Health CO-OP Policy Committee**
05/6/2026	**Added Licensed Alcohol Counselor for referral option**

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