KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Mental Health – Partial Hospitalization & Day Treatment

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	Medicare Benefit Policy Manual Chapter 2 and Chapter 4.
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None

For Non-Medicare Members

Kaiser Permanente has elected to use the MCG* Partial Hospital Behavioral Health Level of Care, Adult (B-KP-901-PHP) for medical necessity determinations.

Kaiser Permanente has elected to use the MCG* Partial Hospital Behavioral Health Level of Care, Child or Adolescent (B-KP-902-PHP) for medical necessity determinations.

For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the provider portal under Quick Access.

Exclusions:
Partial hospital mental health services will not be authorized if any of the exclusion criteria are met as referenced in the member's coverage contract.

If requesting these services, please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist

***The MCG are proprietary and cannot be published and/or distributed**. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed by our Behavioral Health department, you may request a copy of the criteria that is being used to make the coverage determination. Call the Behavioral Health unit for more information regarding the case under review.

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

In January 2007, Kaiser Permanente Behavioral Health Service adopted and integrated into its clinical review criteria, the MCG for determining appropriate levels of care based on symptoms and functional impairment. These criteria are independently developed and based on a review of the scientific literature, expert input, and clinical practice. In addition, the MCG Criteria are updated annually.

Mental health partial hospital services are provided or authorized with the overall goals of assessing and improving the member's symptoms and function. In addition, Kaiser Permanente Behavioral Health Services

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operationally defines clinically indicated services as "services for mental health conditions that are having a clinically significant impact on an individual's social, medical, and/or occupational functioning."

Partial hospitalization designates a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care which meets the standards for licensure as a partial hospital program. The program is usually offered in an inpatient setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment and 20 or more hours of treatment per week. Patients are expected to participate 5 to 7 days per week. Patient must be medically stable and live near treatment setting.

Service authorization decisions are also based on the member's contractually covered services and MCG Guidelines Behavioral Health criteria.

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® or HCPC Codes	Description
No specific codes	

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Date Created	Date Reviewed	Date Last Revised
12/14/06	04/06/2010[MDCRPC], 02/10/2011[MDCRPC], 12/06/2011[MDCRPC], 10/02/2012[MDCRPC], 08/06/2013[MPC], 02/04/2014[MPC], 06/03/2014[MPC], 04/07/2015[MPC], 02/02/2016[MPC], 12/06/2016[MPC], 07/11/2017[MPC], 05/01/2018[MPC], 05/07/2019[MPC], 05/05/2020[MPC], 05/04/2021[MPC], 05/03/2022[MPC], 05/02/2023[MPC]	07/11/2017

[MDCRPC] Medical Director Clinical Review and Policy Committee
[MPC] Medical Policy Committee

Revision History	Description
02/02/2016	Adopted MCG 19th Ed. guidelines
07/11/2017	Adopted MCG 21st Ed. guidelines

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