Summary of Clinical Practice Guidelines and Medical Necessity Criteria – 2020

The clinical practice guidelines adopted by Carisk have been developed by recognized medical specialty societies using a scientifically sound, evidence-based development process. The practice guidelines are reviewed and approved by Carisk's Quality Improvement Committee which includes actively practicing clinicians from Carisk's network.

The adopted clinical practice guidelines are publicly accessible from the American Psychiatric Association (APA), American Academy of Pediatrics (AAP), and Academy of Psychosomatic Medicine (APM) websites. All practitioners are informed of the guidelines annually in a Practitioner Communication Letter. Practitioners are directed to Carisk's Web site to access the guidelines. The website contains links to the online versions of the practice guidelines, which are frequently reviewed and updated to reflect any guideline revisions or change of location. Links are also added when new guidelines are adopted.

The guidelines highlighted in yellow are considered "legacy guidelines", based on the web excerpt below from the American Psychiatric Association:

APA developed and published 23 practice guidelines from 1992 to 2010, including multiple second and third editions. Fourteen of the guidelines are available in this section. The process used to develop these guidelines is described here. These guidelines are more than 5 years old and have not yet been updated to ensure that they reflect current knowledge and practice. In accordance with national standards, including those of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse, these guidelines can no longer be assumed to be current.

PRACTICE GUIDELINES

1. Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition, (American Psychiatric Association)

March 2020 review: no changes, link good

Website: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf.

The *Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition,* consists of three parts (Parts A, B, and C) and many sections, not all of which will be equally useful for all readers. The following guide is designed to help readers find the sections that will be most useful to them.

Part A, "Treatment Recommendations," is published as a supplement to the *American Journal of Psychiatry* and contains general and specific treatment recommendations. Section I summarizes the key recommendations of the guideline and codes each recommendation according to the degree of clinical confidence with which the recommendation is made. Section II is a guide to the formulation and implementation of a treatment plan for the individual patient. Section III, "Specific Clinical Features Influencing the Treatment Plan," discusses a range of clinical considerations that could alter the general recommendations discussed in Section I.

Part B, "Background Information and Review of Available Evidence," and Part C, "Future Research Needs," are not included in the American Journal of Psychiatry supplement but are provided with Part A in the complete guideline, which is available in print format from American Psychiatric Publishing, Inc., and online through the American Psychiatric Association (http://www.psychiatryonline.com). Part B provides an overview of major depressive disorder, including general information on natural history, course, and epidemiology. It also provides a structured review and synthesis of the evidence that underlies the recommendations made in Part A. Part C draws from the previous sections and summarizes areas for which more research data are needed to guide clinical decisions.

2. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (American Academy of Pediatrics)

March 2020 review: no changes, link good

Website: ***http://pediatrics.aappublications.org/content/128/5/1007***

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being, and social interactions of children; the American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000; recommendations for treatment followed in 2001.

Summary of key action statements:

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).
2. To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria have been met (including documentation of impairment in more than 1 major setting); information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).
4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).
5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:
    1. For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).
    2. For *elementary school–aged children (6–11 years of age)*, the primary care clinician should prescribe US Food and Drug Administration–approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.

3. For *adolescents (12–18 years of age)*, the primary care clinician should prescribe Food and Drug Administration–approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.

6. The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

3. Practice Guideline for the Treatment of Patients with Panic Disorder, Second Edition, (American Psychiatric Association)

March 2020 review: no changes, link good

Website:
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/panicdisorder.pdf

- Treatment Recommendations
  - Executive Summary
    - Coding System
    - Psychiatric Management
    - Formulation and Implementation of a Treatment Plan
    - Maintaining or Discontinuing Treatment after Response
  - Formulation and Implementation of a Treatment Plan
    - Psychiatric Management
    - Choosing a Treatment Setting
    - Choosing an Initial Treatment Modality
    - Evaluating whether the treatment is working
    - Determining if and when to change treatment
    - Approaches to try when a first line treatment is unsuccessful
    - Specific psychosocial interventions
    - Specific pharmacological interventions
    - Maintaining or discontinuing treatment after response
  - Specific Clinical Features influencing the treatment plan
    - Psychiatric factors
    - Concurrent general medical conditions
    - Demographic variables
- Background Information and Review of Available Evidence
  - Disease Definition, Natural History, and Epidemiology
    - Diagnosis of panic disorder
    - Specific features of panic disorder
    - Natural history and course
    - Epidemiology and associated feature
  - Review and Synthesis of Available Evidence
    - Interpreting results from studies of treatments for panic disorder
    - Specific psychosocial interventions
    - Pharmacological interventions
    -
- Future Research Needs

4. Practice Guideline for the Treatment of Patients with Bipolar Disorder (Second Edition) , (American Psychiatric Association)

March 2020 review: no changes, link good

Website: ***http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf***

Guideline Watch:
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar-watch.pdf

- Treatment Recommendations for Patients with Bipolar Disorder
  - Executive Summary of Recommendations
    - Psychiatric Management
    - Acute Treatment
    - Maintenance Treatment
  - Formulation and Implementation of a Treatment Plan
    - Psychiatric Management
    - Acute Treatment
    - Maintenance Treatment
  - Special Clinical Features influencing the Treatment Plan
    - Psychiatric Features
    - Demographic and Psychosocial Factors
    - Concurrent General Medical Conditions
- Background Information and Review of Available Evidence
  - Disease Definition, Natural History and Course, and Epidemiology
    - Definition of Bipolar Disorder
    - Natural History and Course
    - Epidemiology
  - Review and Synthesis of Available Evidence
    - Somatic Treatments of Acute Manic and Mixed Episodes
    - Somatic Treatments of Acute Depressive Episodes
    - Rapid Cycling
    - Maintenance Treatment
    - Psychosocial Interventions
    - Somatic Therapies for Children and Adolescents
- Future Research Needs
  - General Principles
  - Acute Treatment
    - Manic and Mixed Episodes
    - Depressive Episodes
    - Rapid Cycling
  - Maintenance Treatment
  - Psychosocial Interventions

5. Practice Guideline For The Treatment Of Patients With Substance Use Disorders, 2nd Edition, (American Psychiatric Association)

March 2020 review: no changes, link good

Website:
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

Guideline Watch:
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf

Since the publication in May 2006 of APA's *Practice Guideline for the Treatment of Patients With Substance Use Disorders,* 2nd Edition (1), results have been reported for a multisite randomized, controlled trial evaluating the efficacy of medication, behavioral therapies, and their combinations for treatment of alcohol dependence in nonspecialty treatment settings (the COMBINE study, 2). In addition, two novel pharmacotherapies have been approved for use in the treatment of nicotine dependence (varenicline) and alcohol dependence (intramuscular naltrexone). This watch describes these developments.

- Treatment Recommendations for Patients With Substance Use Disorders
  - Executive Summary of Recommendations
    - Coding System
    - General Treatment Principles
    - Nicotine Use Disorders: Treatment Principles and Alternatives
    - Alcohol Use Disorders: Treatment Principles and Alternatives
    - Marijuana Use Disorders: Treatment Principles and Alternatives
    - Cocaine Use Disorders: Treatment Principles and Alternatives
    - Opioid Use Disorders: Treatment Principles and Alternatives
  - General Treatment Principles And Alternatives
    - Goals of Treatment
    - Assessment
    - Treatment Settings
    - Psychiatric Management
    - Somatic Treatments
    - Psychosocial Treatments
    - Clinical Features Influencing Treatment
    - Legal and Confidentiality Issues
  - Treatment of Nicotine Dependence
    - Overview
    - Assessment
    - Treatment Settings
    - General Approach to Treatment
    - Somatic Treatments
    - Psychosocial Treatments
    - Treatment of Smokers on Smoke-Free Wards
    - Clinical Features Influencing Treatment
  - Treatment of Alcohol-Related Disorders
    - Overview
    - Treatment Setting
    - Somatic Treatments
    - Psychosocial Treatments
    - Clinical Features Influencing Treatment
  - Treatment of Marijuana-Related Disorders
    - Overview
    - Treatment Setting
    - Somatic Treatments
    - Psychosocial Treatments
    - Pregnancy

- Treatment of Cocaine-Related Disorders
  - Overview
  - Treatment Setting
  - Somatic Treatments
  - Psychosocial Treatment
  - Clinical Features Influencing Treatment

- Treatment of Opioid-Related Disorders
  - Overview
  - Treatment Setting
  - Somatic Treatments
  - Psychosocial Treatment
  - Clinical Features Influencing Treatment

- Background Information and Review of Available Evidence
  - Disease Definition, Natural History and Course, and Epidemiology
    - Disease Definition and Diagnostic Features
    - Natural History and Course
    - Epidemiology

  - Review and Synthesis of Available Evidence
    - Nicotine Dependence
    - Alcohol-Related Disorders
    - Marijuana-Related Disorders
    - Cocaine-Related Disorders
    - Opioid-Related Disorders

- Future Research Needs

6. Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, (American Psychiatric Association)

March 2020 review: no changes, link good

Website: ***http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf***

- Assessment, Treatment, and Risk Management Recommendations
  - Executive Summary of Recommendations
    - Definitions and General Principles
    - Suicide Assessment
    - Estimation of Suicide Risk
    - Psychiatric Management
    - Specific Treatment Modalities
  - Assessment of Patients with Suicidal Behaviors
    - Overview
    - Conduct a thorough psychiatric evaluation
    - Specifically inquire about suicidal thoughts, plans, and behaviors
    - Estimate suicide risk
    - Additional considerations when evaluating patients in specific treatment settings
  - Psychiatric Management

        - Establish and maintain a therapeutic alliance
        - Attend to the patient's safety
        - Determine a treatment setting
        - Develop a plan of treatment
        - Coordinate care and collaborate with other clinicians
        - Promote adherence to the treatment plan
        - Provide education to the patient and family
        - Reassess safety and suicide risk
        - Monitor psychiatric status and response to treatment
        - Obtain consultation, if indicated
    - Specific Treatment Modalities
        - Somatic therapies
        - Psychotherapies
    - Documentation and Risk Management
        - General risk management and documentation issues specific to suicide
        - Suicide contracts: usefulness and limitations
        - Communication with significant others
        - Management of suicide in one's practice
        - Mental health interventions for surviving family and friends after a suicide
- Background Information and Review of Available Evidence
    - Review and Synthesis of Available Evidence
        - Factors altering risk of suicide and attempted suicide
        - Psychiatric assessment techniques
        - Special issues
        - Somatic therapies
        - Psychotherapies
- Future Research Needs

7. Practice Guideline for the Treatment of Patients with Schizophrenia, (American Psychiatric Association)

March 2020 review: no changes, link good

Website:
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf

Guideline Watch:
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf

GUIDELINE WATCH (SEPTEMBER 2009): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA: INTRODUCTION

This watch highlights key research studies published since that date. The studies were identified by a MEDLINE literature search for meta-analyses and randomized, controlled trials published between 2002 and 2008, using the same key words used for the literature search performed for the 2004 guideline.

With regard to pharmacotherapy, there have been several important randomized trials of antipsychotics. For chronic schizophrenia, trials include the National Institute of Mental Health (NIMH) Clinical Antipsychotic Trial for Intervention Effectiveness (CATIE) and the United Kingdom–funded Cost Utility of the Latest Antipsychotics in Schizophrenia (CUtLASS). For first-episode schizophrenia, there are two industry-funded trials, the European First Episode Schizophrenia Trial (EUFEST)—funded by AstraZeneca, Pfizer, and Sanofi-Aventis—and the Comparison of Atypicals for First Episode Schizophrenia (CAFE)—funded by

AstraZeneca. For early-onset schizophrenia, there is one trial, the NIMH-funded Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS). These trials point to a reconsideration of treatment with the antipsychotics perphenazine and molindone and by extension other first-generation antipsychotics, with the possible exception of haloperidol, for which some trials have shown greater rates of extrapyramidal side effects or less favorable clinical response (2). In addition, a recent population-based cohort study (3) that encompassed 11 years of follow-up showed decreased rates of mortality with perphenazine as compared with other first- and second-generation antipsychotic agents; only clozapine use was associated with lower rates of overall mortality.

In addition, randomized controlled trials have demonstrated the safety and efficacy of a new antipsychotic, paliperidone, leading to its approval by the U.S. Food and Drug Administration (FDA). Several controlled clinical trials have investigated treatments to prevent or treat antipsychotic-related weight gain and metabolic changes. Additionally, there have been promising clinical trials of bupropion and behavioral interventions to reduce smoking in schizophrenia patients.

With regard to psychosocial treatments, new studies lend some additional support to the treatments recommended in the 2004 guideline. In addition, combinations of treatments have begun to be tested to enhance supported employment and social skills training. An evidence base has developed for interventions for obesity and for smoking cessation. There also has been continued study of cognitive remediation and peer support and peer-delivered services, which have the potential to play a useful role in recovery.

    - Other Somatic Therapies
    - Specific Psychosocial Interventions

- Future Research Directions

8. Practice Guideline (Policy): Management of Children With Autism Spectrum Disorders, (American Academy of Pediatrics)

March 2020 review: no changes, link good

Website: ***http://pediatrics.aappublications.org/content/120/5/1162.full***

Clinical Report: Management of Children With Autism Spectrum Disorders. *Pediatrics*. 2007;120(5):1162–1182. Reaffirmed August 2014

- ABSTRACT
- INTRODUCTION
- EDUCATIONAL INTERVENTIONS
- MEDICAL MANAGEMENT
- FAMILY SUPPORT
- CONCLUSIONS
- Council on Children With Disabilities Executive Committee, 2006–2007
- Liaisons
- Staff
- Contributors
- REFERENCES
- RESOURCE FOR FAMILIES

9. Practice Guidelines for Psychiatric Consultation in the General Medical Setting

March 2020 review: no changes, link good

https://pdfs.semanticscholar.org/73eb/318a2b4b2adefa484c74d49173ea9c29a9c7.pdf

The purpose in developing psychiatric consultation guidelines is to broadly instruct and guide practitioners who care for patients with psychiatric symptoms in a general medical setting. These guidelines will review the assessments and interventions that are necessary for management of patients with comorbid medical and psychiatric conditions. The development of guidelines for psychiatric consultation is important because significant numbers of patients with unrecognized, yet serious, neuropsychiatric disorders are inadequately assessed and managed, and psychological distress induced by the highly technological world of the general medical setting is often ignored.

These guidelines are not intended to delineate universal, professionally mandated regulations and actions. Instead, they are meant to serve as an outline for the training and knowledge that are generally necessary to guide the clinician's approach to the patient.[1]

In general, the aims of psychiatric consultation in the medical/surgical setting are 1) to ensure the safety and stability of the patient within the medical environment, 2) to collect sufficient history and medical data from appropriate sources to assess the patient and formulate the problem, 3) to conduct a mental status examination and neurological and physical examinations as necessary, 4) to establish a differential diagnosis, and 5) to initiate a treatment plan.

Consultation-liaison (C-L) psychiatry is the subspecialty of psychiatry concerned with medically and surgically ill patients.[2] The C-L consultant must have an extensive clinical understanding of physical/neurological disorders and their relation to abnormal illness behavior. The C-L consultant must be a skilled diagnostician, be able to tease apart and formulate the patient's multiaxial disorders, and able to develop an effective treatment plan. The C-L consultant must also have knowledge of psychotherapeutic and psychopharmacological interventions as well as knowledge of the wide array of medicolegal aspects of psychiatric and medical illness and hospitalization. The psychiatric physician, by virtue of his/her professional stature and knowledge, has the ability to supervise a multidisciplinary team.

These proposals for care supplement those developed for *Psychiatric Training in C-L Psychiatry* by the Academy of Psychosomatic Medicine (APM)[3,4] and the practice guidelines developed by the American Psychiatric Association (APA).[1,5–9] These current proposals are also related to the recommendations reported in *Psychological Care of Medical Patients*, drafted by the Joint Working Party of the Royal College of Physicians and Psychiatrists[10] and to the goals of *Fellowship Training in C-L Psychiatry* put forth by the Academy of Psychosomatic Medicine.[11] Although primarily based on consensus, they include, to the extent possible, the desirable attributes (e.g., validity, clinical applicability, clarity) delineated by the Institute of Medicine.[12]

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10. Practice Guidelines for the Psychiatric Evaluation of Adults

March 2020 review: no changes, link good

https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890426760.pe02

> **Background and Development** Process These Practice Guidelines for the Psychiatric Evaluation of Adults mark a transition in the American Psychiatric Association's Practice Guidelines. Since the publication of the Institute of Medicine (2011) report, "Clinical Practice Guidelines We Can Trust," there has been an increasing focus on using clearly defined, transparent processes for rating the quality of evidence and the strength of the overall body of evidence in systematic reviews of the scientific literature. These guidelines were developed using a process intended to be consistent with the recommendations of the Institute of Medicine (2011), the Principles for the Development of Specialty Society Clinical Guidelines of the Council of Medical Specialty Societies (2012), and the requirements of the Agency for Healthcare Research and Quality (AHRQ) for inclusion of a guideline in the National Guideline Clearinghouse. Parameters used for the guidelines' systematic review are included with the full text of the guidelines; the development process is fully described in a document available on the APA Web site: http:/ /www.psychiatry.org/File%20Library/Practice/APA-Guideline-

Development-Process--updated2011-.pdf. To supplement the expertise of members of the guideline work group, we used a "snowball" survey methodology to identify experts on psychiatric evaluation and solicit their input on aspects of the psychiatric evaluation that they saw as likely to improve specific patient outcomes (Yager et al. 2014). Results of this expert survey are included with the full text of the practice guideline.

Goals and Scope of Guidelines for the Psychiatric Evaluation of Adults Despite the difficulties in obtaining quantitative evidence from randomized trials for practice guidelines such as psychiatric evaluation, guidance to clinicians can still be beneficial in enhancing care to patients. Thus, in the context of an initial psychiatric evaluation, a major goal of these guidelines is to improve the identification of psychiatric signs and symptoms, psychiatric disorders (including substance use disorders), other medical conditions (that could affect the accuracy of a psychiatric diagnosis), and patients who are at increased risk for suicidal or aggressive behaviors. Additional goals relate to identifying factors that could influence the therapeutic alliance, enhance clinical decision making, enable safe and appropriate treatment planning, and promote better treatment outcomes. Finally, the psychiatric evaluation is the start of a dialog with patients about many factors, including diagnosis and treatment options. Further goals of these guidelines are to improve collaborative decision making between patients and clinicians about treatment-related decisions as well as to increase coordination of psychiatric treatment with other clinicians who may be involved in the patient's care.

Guideline Statements The following represents a summary of the recommendations and suggestions compiled from all Practice Guidelines for the Psychiatric Evaluation of Adults, with some statements being a part of more than one of these guidelines. In the context of these guideline statements, it is important to note that assessment is not limited to direct examination of the patient. Rather, it is defined as "[t]he Copyright 2016, American Psychiatric Association. APA makes this practice guideline freely available to promote its dissemination and use; however, copyright protections are enforced in full. No part of this guideline may be reproduced except as permitted under Sections 107 and 108 of U.S. Copyright Act. For permission for reuse, visit APAP Permissions & Licensing Center at http://www.appi.org/customer-service/permissions. 4 APA Practice Guidelines process of obtaining information about a patient through any of a variety of methods, including face-to-face interview, review of medical records, physical examination (by the psychiatrist, another physician, or a medically trained clinician), diagnostic testing, or history-taking from collateral sources." The evaluation may also require several meetings, with the patient, family, or others, before it can be completed. The amount of time spent depends on the complexity of the problem, the clinical setting, and the patient's ability and willingness to cooperate with the assessment. This summary is organized according to common headings of an evaluation note. As noted above, the guidelines are not intended to be comprehensive, and many aspects of the psychiatric evaluation are not addressed by these recommendations and suggestions. Recommendations for the initial psychiatric evaluation of a patient appear in bold font, whereas suggestions appear in italic font. The strength of supporting research evidence for these recommendations and suggestions is given rating C (low) because of the difficulties in studying psychiatric assessment approaches in controlled studies as described above. References to the specific guideline in which the recommendation or suggestion is found are denoted by the following footnotes: 1 Guideline I. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History 2 Guideline II. Substance Use Assessment 3 Guideline III. Assessment of Suicide Risk 4 Guideline IV. Assessment of Risk for Aggressive Behaviors 5 Guideline V. Assessment of Cultural

Factors 6 Guideline VI. Assessment of Medical Health 7 Guideline VII. Quantitative Assessment 8 Guideline VIII. Involvement of the Patient in Treatment Decision Making 9 Guideline IX. Documentation of the Psychiatric Evaluation.

For Major Depressive Disorder in Adults, Carisk measures:

- The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

For Attention Deficit Hyperactivity Disorder, Carisk measures:

- The percentage of members 6-12 years of age who, after receiving a new outpatient prescription for ADHD medication, had one follow-up visit with a practitioner with prescribing authority within the next 30 days.
- The percentage of members defined above who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months).

For Schizophrenia, Carisk measures:

- The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
- The percentage of frequent readmitters who have outpatient therapy between hospitalizations.

MEDICAL NECESSITY CRITERIA

Mihalik Group's Medical Necessity Manual for Behavioral Health

March 2020: Updated Version 8.6.0 was released on September 1, 2019 and expires on August 31, 2020. References were updated but no major revisions were completed.
March 2019: Updated Version 8.5.0 was released on September 1, 2018 and expires on August 31, 2019. References were updated but no major revisions were completed.

- ***The criteria remain consistent with current scientific literature.***

Website: N/A. The section pertaining to the practitioner's level of care is provided on request.

The Mihalik Group's comprehensive *Medical Necessity Manual for Behavioral Health* guides utilization management decision-makers through the process of determining the most appropriate level of care for members presenting for mental health and substance use services. It is a symptom-driven set of criteria that focuses on the severity and degree of impairment caused by the member's presenting situation and drives decision for optimal care in a clear, concise and impartial manner.

Medical necessity decisions involve consideration of two related, but distinct, dimensions:

- The characteristics of the service setting
- The medical necessity of the proposed services

In addition to medical necessity, it is also essential to know which setting will deliver safe, effective treatment without providing excessive and unnecessary, or inadequate care. This *Manual* describes the characteristics of seventeen different service settings which allow UM decision-makers to precisely match the clinical condition of an individual member with an appropriate service setting.

The *Manual* contains treatment initiation and treatment continuation criteria for Adults and for Children and Adolescents for each of the seventeen service settings, along with the process for applying the criteria. Each Level of Care Criteria set is intended to stand alone. This enables the decision-maker to find easily all relevant criteria in one place, reducing the amount of time needed to reach a determination.

Criteria for psychological and neuropsychological testing, applied behavioral analysis, eating disorders, substance use requiring medical detoxification, and electroconvulsive therapy are also included.

The *Manual* also contains Carisk plan-specific amendments related to Florida Medicaid.