Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

2024-2025 Medicaid Acute Behavioral Health Services Benefit Plan

Service Code(s):	***Services Included (Sorted by Alphabetical Order):***
160	Acute and Subacute Services Provided in an Institute for Mental Disease (Non-State Facilities and State ADATCs)
160	Acute and Subacute Services Provided in an Institute for Mental Disease (State Facilities, excluding State ADATCs)
T2016 U5, T2016 U6	Behavioral Health Crisis Assessment and Intervention
S9484HA	Facility-Based Crisis Service for Children and Adolescents
Y2343	Inpatient Behavioral Health Services: Behavioral Health Treatment Milieu Therapy
100	Inpatient Behavioral Health Services: Inpatient Hospital Psychiatric Treatment (MH)
100, 160	Inpatient Behavioral Health Services: Medically Managed Intensive Inpatient Services (Using DRG)
100, 160	Inpatient Behavioral Health Services: Medically Managed Intensive Inpatient Withdrawal Management Services (Using DRG)
H0010	Medically Monitored Inpatient Withdrawal Management Service
H2011	Mobile Crisis Management

Codes / modifier combinations not mentioned for specialized services will be found within contracts.
For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.
When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.

S9484	Professional Treatment Services in Facility-Based Crisis Program

Inpatient Behavioral Health Services

Inpatient Behavioral Health Services provide hospital treatment in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for members with acute psychiatric or substance use problems.

For members with substance use disorder, Inpatient Behavioral Health Services cover:
- Medically Managed Intensive Inpatient Services- Adolescent
- Medically Managed Intensive Inpatient Services- Adult
- Medically Managed Intensive Withdrawal Management Services- Adult

For members with mental health disorders, Inpatient Behavioral Health Services cover:
- Inpatient Psychiatric Hospitalization- Child and Adolescent
- Inpatient Psychiatric Hospitalization- Adult

Definitions and Abbreviations
- ACT: Assertive Community Treatment
- ADATC: Alcohol and Drug Abuse Treatment Center
- American Society of Addiction Medicine Criteria: a treatment criterion for addictive, substance-related, and co-occurring condition
- CADT: Child and Adolescent Day Treatment
- CST: Community Support Team
- DRG: Diagnosis-Related Group
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid member under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).
- H&P: History and Physical
- IIH: Intensive In-Home Services
- IMD: Institute of Mental Disease
- Medication Assisted Treatment (MAT): the use of medications, in combination with counseling and behavioral therapist, to provide a “whole patient’ approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration, and MAT programs are clinically driven and tailored to meet each member’s needs.

- MST: Multisystemic therapy
- MCSART: Medical Community Substance Abuse Residential Treatment
- NMCSART: Non-Medical Community Substance Abuse Residential Treatment
- Psych Eval: Psychiatric Evaluation
- SACOT: Substance Abuse Comprehensive Outpatient
- SAIOP: Substance Abuse Intensive Outpatient
- Tx: Treatment

General Information for State Psychiatric Hospitals and ADATCs

- Except for Emergency Services, facilities must verify Member eligibility. For Emergency Services, facilities shall verify Member eligibility no later than the next business day after the Member is stabilized or the facilities learning the individual may be a Member, whichever is later.
- Facilities must initiate the discharge planning process promptly following an individual's admission to the facility.
- Provide the Discharge Summary to the selected community provider(s) at the earliest practicable time, within at least 72 hours after discharge.
- Where applicable, Trillium will work cooperatively with the facility regarding a discharge service order addressing the members individual needs prior to discharge and make best efforts to authorize and/or deny services requested to begin upon discharge within three (3) business days after receipt of the discharge service order.
- Upon the denial of a requested authorization, Trillium may inform the member's attending physician or ordering provider of the availability of a peer-to-peer conversation within one business day.

General Benefit Plan Limits

- *Auth to a Different Provider:* The requested service cannot be authorized if another provider is currently authorized to provide the requested service, and two providers are not permitted to provide that service at the same time.
- *Backdated Request:* Service dates requested prior to the receipt of the authorization request cannot be authorized.
- *Contract Issue:* The requested service cannot be authorized if the provider is experiencing a contract related issue preventing the service from being approved.
- *Insurance Coverage Expired:* The requested service cannot be authorized if a member does not have active insurance coverage.
- *Missing Individual Support Plan (ISP)/Care Plan/Person Centered Plan (PCP) Information:* The requested service cannot be authorized if the ISP/ Care Plan/ PCP is missing any of the following: 1) The signature page, to include the check boxes not being complete, a missing signature, an undated signature, an electronic signature missing the date stamp, and/or if the signature is dated before the date of the ISP/ Care Plan/ PCP; 2) Is missing a goal for the service requested; 3) Is missing the units/frequency of service requested or if the units

requested exceed the frequency detailed in the ISP/ Care Plan/ PCP, and/or; 4) Is missing the Comprehensive Crisis Prevention and Intervention Plan.

- *More than 30 Days in Advance:* The service cannot be authorized if requested more than 30 days in advance. A member's clinical picture can change over time, so medical necessity for a service cannot be established based on a clinical picture that is more than 30 days old.
- *No Documentation:* The requested service cannot be authorized because the request does not include the required documentation, as detailed in the applicable Clinical Coverage Policy, the service definition, or the Benefit Plan. If required, this can include: 1) A missing or invalid service order; 2) A missing ISP/ Care Plan/ PCP; 3) A missing discharge/ transition plan, and/or; 4) Missing information on an IDD member, like a missing SNAP or a missing psychological evaluation that supports the DD diagnosis.
- *No ISP/Care Plan/PCP Update:* The requested service reauthorization cannot be authorized if an updated or revised ISP/ Care Plan/ PCP to not submitted.
- *No New Annual ISP/ Care Plan/ PCP:* The requested service cannot be authorized if the ISP/ PCP annual rewrite has not been completed. This includes when an ISP/ Care Plan/ PCP is submitted that is more than a year old.
- *Out of Catchment:* Trillium is unable to authorize the requested service if a member's Medicaid county of residence is outside of Trillium catchment area.
- *Service Exclusion:* The requested service cannot be authorized if the member is currently authorized for a service that is an exclusion to the requested service.
- *Third Party Insurance:* The requested service cannot be authorized if the member has private insurance, and the provider should seek authorization from primary insurance source. Medicaid is the payor of last resort.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Acute and Subacute Services Provided in an Institute for Mental Disease **(*Non-State Facilities and State ADATC*)** Code(s): 160	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) *for acute and subacute inpatient psychiatric disorders*. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Providers must follow the requirements for inpatient level of care outlined in Clinical Coverage Policy (CCP) 8-B, Inpatient Behavioral Health Services.	**Pass-Through Period:** Prior authorization is not required for the first 72 hours of service. **Initial Requests (after pass-through)**: **1.** TAR: prior authorization required within the first 72 hours of service initiation. **2.** CCA or DA: Required. See CCP Section 7.5 for additional requirements. An H&P/ Initial Psychiatric Evaluation may satisfy this requirement. **3.** Service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement. **4.** Service Plan: Required **5.** Submission of all records that support the individual has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required. **2.** Updated Service Plan: Required **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Members receiving tx for MH diagnoses are limited to no more than 15 authorized days each calendar month. For admissions spanning two consecutive months, the total length of stay may exceed 15 days, but no more than 15 days may be authorized in each month. There is not a day limit for members receiving SU services. **2.** For State ADATC's, the initial authorization will be for at least 7 days. **3.** Reauth requests must be submitted prior to the end of the current auth. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. **4.** Retrospective auths due to late submissions is not permitted. **Units**: Per diem based on the midnight bed count **Age Group**: Adults aged 21-64 **Place of Service**: Institute for Mental Disease (IMD) **Service Specifics, Limitations/ Exclusions (not all inclusive)**: **1.** The case management component of IIH, MST, CST, ACT, SAIOP, SACOT & CADT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. **2.** Medicaid eligibility must be verified each time a service is rendered. **3.** Discharge Planning shall begin upon admission to this service. **4.** Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with the MCD TAR. **5.** Out-of-State emergency admissions do not require prior approval. The provider must contact Trillium within one business day of the emergency service or emergency admission.	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers JCB #J277: Authorization Requests for Services When a Third-Party Payer is Primary JCB #J265: Clarification of Services in an IMD JCB #J348: SUD IMD Clarification APSM 45-2 Records Management and Documentation Manuals

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Acute and Subacute Services Provided in an Institute for Mental Disease **(*State Facilities, excluding State ADATCs*)** Code(s): 160	This is an organized service that provides intensive evaluation and treatment delivered in an acute care inpatient setting by medical and nursing professionals. This service focuses on reducing acute psychiatric symptoms through in-person, structured group and individual treatment.	**Initial Requests**: **1.** TAR: Required **2.** I/DD Exception Form: Required per Diversion Law, if applicable. **3.** CCA or DA: Required. See CCP Section 7.5 for additional requirements. An H&P/ Initial Psychiatric Evaluation may meet this requirement. **4.** Service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement. **5.** Service Plan: Required **6.** Submission of all records that support the member has met the medical necessity criteria. The state facility shall provide Trillium with all necessary clinical information needed for the utilization management process. **Reauthorization Requests**: Not applicable	**Length of Stay**: **1.** Provider must submit a TAR covering the member's length of stay on the next business day following the Individual's discharge. **2.** Member's that present directly to the facility as an emergency commitment or as a self-referral, the facility shall submit a TAR by the next business day. **3.** Members receiving tx for MH diagnoses are limited to no more than 15 authorized days each calendar month. For admissions spanning two consecutive months, the total length of stay may exceed 15 days, but no more than 15 days may be authorized in each month. There is not a day limit for members receiving SU services. **Units**: 1 unit per day for up to 15 days per month. **Age Group**: Adults aged 21-64 **Place of Service**: Institute for Mental Disease (IMD) **Service Specifics, Limitations/ Exclusions (not all inclusive)**: **1.** Trillium will issue an auth decision within 14 days after receipt of the TAR. **2.** The case management component of IIH, MST, CST, ACT, SAIOP, SACOT & CADT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. **3.** Medicaid eligibility must be verified each time a service is rendered. **4.** Discharge Planning shall begin upon admission to this service. **5.** Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with the MCD TAR.	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers JCB #J277: Authorization Requests for Services When a Third-Party Payer is Primary JCB #J265: Clarification of Services in an IMD JCB #J348: SUD IMD Clarification APSM 45-2 Records Management and Documentation Manuals

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
Behavioral Health Crisis Assessment and Intervention (BH-CAI) Code(s): **T2016 U5**: At a Tier III BHUC **T2016 U6**: At a Tier IV BHUC	This service is designed to provide triage, crisis risk assessment, evaluation, and intervention within a Behavioral Health Urgent Care (BHUC) setting for members experiencing a behavioral health crisis meeting emergent or urgent triage standards. Individuals receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care. A BHUC setting is an alternative, but not a replacement, to a community hospital Emergency Department.	**Initial & Concurrent Requests**: No prior authorization is required for this service. **Other**: **1.** Tier IV BHUC holds IVC designation and completes IVC First Evaluations. **2.** Within a BHUC setting, law enforcement is available on site to maintain custody and facilitate drop off by community first responders or other law enforcement in instances where a petition has been filed or an IVC has been initiated. **3.** This BH-CAI service is comprised of four elements. Central to it is the clinical assessment by a licensed clinician. Without that component the service is not billable. Other core elements include a triage determination, crisis intervention and disposition planning. **4.** BHUC services are either Tier III or Tier IV. A Tier III BHUC operates at least 12 hours per day 7 days a week, 365 days a year w/ at least 6 hours occurring after 4:00 PM each day. A Tier IV BHUC is open 24 hours a day, 7 days a week, 365 days a year. This service is designed to be completed during the defined business hours. **5.** For community discharges, it is expected the consumer will receive a copy of the crisis plan and follow up instructions at the time of release.	**Length of Stay & Units**: One unit = 1 event with a clinical assessment by a licensed clinician (required for billing). Individuals receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care. **Place of Service**: Behavioral Health Urgent Care (BHUC) **Level of Care**: Members experiencing a behavioral health crisis with any combination of MH, SUD and co-occurring BH/IDD issue **Age Group**: Children, Adolescents & Adults (Individuals 4 years or older) **Service Specifics, Limitations/ Exclusions (not all inclusive)**: None noted	In-Lieu Of Behavioral Health Crisis Assessment and Intervention Service Definition APSM 45-2 Records Management and Documentation Manuals

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Facility-Based Crisis Service for Children and Adolescents Code(s): S9484HA	This is a service that provides an alternative to hospitalization for an eligible member who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility. Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** Service Order: Required, signed by an MD/ DO, PA, NP, or licensed psychologist. **2.** Pre-Admission Nurse Screening: Required, conducted by an RN or LPN under the supervision of an RN to determine medical appropriateness for this LOC and to rule out acute or severe chronic comorbidities that could require complex medical intervention in a higher LOC **3.** Clinical Assessment: A full CCA must be completed prior to DC. **4.** Nursing Assessment: Required within 24 hours of admission **5.** Psychiatric Evaluation: Required within 24 hours of admission **6.** Tx plan: Required to direct tx and interventions during the stay. Must include the goal(s), objectives, tx interventions and the individual responsible for carrying out the intervention. **7.** Care Coordination Referral: If not already linked with a care coordinator, a referral should be made for care coordination within 24 hours of admission. **8.** Discharge/ Aftercare Plan: to include: a) the date, time and location of first follow up appointment; b) the behavioral health services to be provided; c) living and educational or vocational arrangements; d) the members current treatment and care coordination needs; and. e) diagnosis and discharge medications **9.** Crisis Plan: to includes interventions to prevent readmission into a crisis setting **10.** Submission of applicable records that support the member has met the medical necessity criteria. All services are subject to post-payment review.	**Units**: One unit = 1 hour **Level of Care**: If SU applies, ASAM Level 3.7 **Age Group**: Children (ages 6-17). Members 18 to 21 are eligible for FBC Services for Adults. **Place of Service**: Licensed crisis settings **Service Specifics, Limitations/ Exclusions (not all inclusive)**: **1.** Within 24-hrs of admission, provider must contact the MCO to determine if the member is enrolled with another service provider or if the member is receiving care coordination. If the member is not already linked with a care coordinator, a referral must be made. **2.** MCD will not cover Facility-Based Crisis Service delivered to a child or adolescent stepping down from an inpatient level of care. **3.** IDD Exclusion Rules apply [see NCGS 122C-261(f), 122C-262(d), and 122C 263(d)(2)]	Clinical Coverage Policy No: 8A-2, Facility-Based Crisis Service for Children and Adolescents PCP Guidance Documents & Templates APSM 45-2 Records Management and Documentation Manuals

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Inpatient Behavioral Health Services: ***Behavioral Health Treatment Milieu Therapy*** Code(s): **Y2343**: Criterion 5 in an Inpatient Psychiatric Facility	In the event that not all of the criteria for continued acute state in an inpatient psychiatric facility are met, reimbursement may be provided for members through the age of 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at a residential rate established by NC Medicaid if the facility and program services are appropriate for the member's treatment needs	**All Requests**: **1.** TAR: prior authorization required. **2.** Care Coordination Referral: On-going (at least weekly) coordination between the facility and the MCO satisfies this requirement. **3.** Attending Physician Documentation: **A)** Documentation of the member's history of sudden decompensation or measurable regression, and **B)** That the member currently experiences weakness in their environmental support system which is likely to trigger a decomp or regression **4.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Initial requests: Up to 7 units per auth **2.** Reauthorization requests: Up to 7 units per auth. Reauth requests must be submitted prior to the end of the current auth. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. **Units**: Per diem based on the midnight bed count **Age Group**: Children through age 17 **Place of Service**: This service may be provided at a psychiatric hospital or on an inpatient psychiatric unit within a licensed hospital licensed as inpatient psychiatric hospital beds or in State operated facilities. **Service Specifics, Limitations/ Exclusions (not all inclusive)**: **1.** The case management component of IIH, MST, CST, ACT, SAIOP, SACOT & CADT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. **2.** Medicaid eligibility must be verified each time a service is rendered. **3.** Service is EPSDT eligible, but this does not eliminate the requirement for prior approval. **4.** Discharge Planning shall begin upon admission to this service. **5.** Medicaid shall not cover services in a freestanding psychiatric hospital for members over 21 or less than 65 years of age for mental health disorders. **6.** Out-of-State emergency admissions do not require prior approval. The provider must contact Trillium within one business day of the emergency service or emergency admission.	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services Instructions for Use of Service Needs/Discharge Planning Status Form Criterion #5 Service Needs/Discharge Planning Status Form July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers APSM 45-2 Records Management and Documentation Manuals

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Inpatient Behavioral Health Services: ***Inpatient Hospital Psychiatric Treatment (MH)*** Code(s): **100**: Inpatient Behavioral Health Services	This is an organized service that provides intensive evaluation and treatment delivered in an acute care inpatient setting by medical and nursing professionals under the supervision of a psychiatrist. *This service is designed to provide continuous treatment for members with acute psychiatric problems.* This service focuses on reducing acute psychiatric symptoms through in-person, structured group and individual treatment.	**Pass-Through Period:** Prior authorization is not required for the first 72 hours of service. **Initial Requests (after pass-through)**: **1.** TAR: prior authorization required within the first 72 hours of service initiation. **2.** Certificate of Need (CON): Required at admission to a freestanding psych hospital or within 14 calendar days of an emergency admission for members under 21. **3.** CCA or DA: Required. An H&P/ Initial Psychiatric Evaluation may satisfy this requirement. **4.** Service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement. **5.** Service Plan: Required **6.** Submission of all records that support the individual has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required. **2.** Updated Tx Plan/ PCP: Required **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Reauth requests must be submitted prior to the end of the current auth. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. Retrospective auths due to late submissions is not permitted. **2.** For state psychiatric hospitals, the initial auth will be for a minimum of 10 days (including the pass-through days). **Units**: Per diem based on the midnight bed count **Age Group**: Children, Adolescents & Adults **Place of Service**: This service may be provided at a psychiatric hospital or on an inpatient psychiatric unit within a licensed hospital licensed as inpatient psychiatric hospital beds or in State operated facilities. **Service Specifics, Limitations/ Exclusions (not all inclusive):** **1.** The case management component of IIH, MST, CST, ACT, SAIOP, SACOT & CADT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. **2.** Medicaid eligibility must be verified each time a service is rendered. **3.** Service is EPSDT eligible, but this does not eliminate the requirement for prior approval. **4.** Discharge Planning shall begin upon admission to this service. **5.** Medicaid shall not cover services in a freestanding psychiatric hospital for members over 21 or less than 65 years of age for mental health disorders. **6.** Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with the MCD TAR. **7.** Out-of-State emergency admissions do not require prior approval. The provider must contact Trillium within one business day of the emergency service or emergency admission.	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers JCB #J277: Authorization Requests for Services When a Third-Party Payer is Primary APSM 45-2 Records Management and Documentation Manuals CON: Medicaid Inpatient Psychiatric Services Under Age 21

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Inpatient Behavioral Health Services: *Medically Managed Intensive Inpatient Services (Using DRG)* Code(s): **100**: Inpatient Behavioral Health Services **160**: Inpatient Behavioral Health Services in an IMD	This is an *ASAM Level 4 for adolescent and adult members whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care*. The outcome of this level of care is stabilization of acute signs and symptoms of substance use, and a primary focus of the treatment plan should be coordination of care to ensure a smooth transition to the next clinically appropriate level of care.	**Pass-Through Period:** Prior authorization is not required for the first 72 hours of service. **Initial Requests (after pass-through)**: **1.** TAR: prior authorization required within the first 72 hours of service initiation. **2.** CCA or DA: Required, an initial assessment must be completed within 72 hours of admission and updated prior to discharge to determine the next clinically appropriate level of care. See CCP Section 7.5 for specific requirements. **3.** Certificate of Need (CON): Required at admission to a freestanding psych hospital or within 14 calendar days of an emergency admission for members under 21. **4.** Service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement. **5.** Service Plan/ Plan of Care/ Tx Plan: Required **6.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required. **2.** Updated Tx Plan/ PCP: Required **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Initial & Reauthorization requests (after the pass-through): must be submitted prior to the end of the current auth. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. **2.** Retrospective auths due to late submissions is not permitted. **Units**: Per diem based on the midnight bed count **Age Group**: Adolescent and Adult **Place of Service**: This service may be provided in a licensed community hospital or a facility licensed under 10A NCAC 27G .6000, unless provided by an IHS or compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t and 1647a, or provided by a State or Federally operated facility as allowed by §122C-22. (a)(3). This substance use disorder service may be provided in an IMD. **Service Specifics, Limitations/ Exclusions (not all inclusive):** **1.** The case management component of IIH, MST, CST, ACT, SAIOP, SACOT & CADT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. **2.** Discharge planning shall begin upon admission to the service. **3.** This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use. **4.** Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with the MCD TAR. **5.** For ADATCs: For members under the age of 21, admission authorization shall be requested by the facility the next business day following admission if the individual presents directly to the	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers JCB #J277: Authorization Requests for Services When a Third-Party Payer is Primary JCB #J265: Clarification of Services in an IMD JCB #J348: SUD IMD Clarification APSM 45-2 Records Management and Documentation Manuals CON: Medicaid Inpatient Psychiatric Services Under Age 21

			facility, by submitting a completed Non-Covered State Medicaid Plan Services Request Form to the Health Plan. To request re-authorization, the ADATC shall submit a completed Electronic Authorization Request to the Health Plan prior to the expiration of the admission authorization. The form shall be submitted by the ADATC on the last covered day of the existing authorization (or the previous business day if the last covered day occurs on a weekend or holiday).	

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Inpatient Behavioral Health Services: *Medically Managed Intensive Inpatient Withdrawal Management Services (Using DRG)* Code(s): **100**: Inpatient Behavioral Health Services **160**: Inpatient Behavioral Health Services in an IMD	This is an *ASAM Level 4-WM for adult members whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care, 24-hour observation, monitoring, and withdrawal management services in a medically monitored inpatient setting.* The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.	**Pass-Through Period:** Prior authorization is not required for the first 72 hours of service. **Initial Requests (after pass-through)**: **1.** TAR: prior authorization required within the first 72 hours of service initiation. **2.** CCA or DA: Required, an initial assessment must be completed within 72 hours of admission and updated prior to discharge to determine the next clinically appropriate level of care. See CCP Section 7.5 for specific requirements. **3.** Certificate of Need (CON): Required at admission to a freestanding psych hospital or within 14 calendar days of an emergency admission for members under 21. **4.** Service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement. **5.** Service Plan/ Plan of Care/ Tx Plan: Required **6.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required. **2.** Updated Tx Plan/ PCP: Required **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Initial & Reauthorization requests (after the pass-through): must be submitted prior to the end of the current auth. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. **2.** Retrospective auths due to late submissions is not permitted. **Units**: Per diem based on the midnight bed count **Age Group**: 18 and older **Place of Service**: May be provided in a licensed community hospital or a facility licensed under 10A NCAC 27G .6000 unless provided by an IHS or compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t and 1647a, or provided by a State or Federally operated facility as allowed by §122C-22.(a)(3). This substance use disorder service may be provided in an IMD. **Service Specifics, Limitations/ Exclusions (not all inclusive):** **1.** The case management component of IIH, MST, CST, ACT, SAIOP, & SACOT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. **2.** Discharge planning shall begin upon admission to the service. **3.** This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use. **4.** Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with the MCD TAR. **5.** For ADATCs: For members under the age of 21, admission authorization shall be requested by the facility the next business day following admission if the individual presents directly to the	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers JCB #J277: Authorization Requests for Services When a Third-Party Payer is Primary JCB #J265: Clarification of Services in an IMD JCB #J348: SUD IMD Clarification APSM 45-2 Records Management and Documentation Manuals CON: Medicaid Inpatient Psychiatric Services Under Age 21

			facility, by submitting a completed Non-Covered State Medicaid Plan Services Request Form to the Health Plan. To request re-authorization, the ADATC shall submit a completed Electronic Authorization Request to the Health Plan prior to the expiration of the admission authorization. The form shall be submitted by the ADATC on the last covered day of the existing authorization (or the previous business day if the last covered day occurs on a weekend or holiday).	

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Medically Monitored Inpatient Withdrawal Management Service Code(s): H0010	This is an organized facility-based service that is delivered by medical and nursing professionals who provide 24-hour medically directed observation, evaluation, monitoring, and withdrawal management in a licensed facility. This is for a beneficiary whose withdrawal signs and symptoms are sufficiently severe to require 24-hour observation, monitoring, and treatment in a medically monitored inpatient setting. A beneficiary at this level of care does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** CCA: completed within three calendar days of the admission **2.** Service Plan: Required, regularly reviewed detailing the members' progress with the service **3.** Service Order: Required, signed by a physician, PA, or NP. **4.** Discharge Planning: Step-down discharge ASAM LOC must be determined as part of the CCA **5.** Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) score(s): Required **6.** Submission of applicable records that support the member has met the medical necessity criteria. All services are subject to post-payment review.	**Units**: One unit = 1 day **Age Group**: Adolescents and Adults (aged 18 and older) **Level of Care**: ASAM Level 3.7 WM. The ASAM Score must be supported with detailed clinical documentation on each of the six ASAM dimensions. **Service Specifics, Limitations/ Exclusions (not all inclusive):** **1.** Provider shall verify each Medicaid beneficiary's eligibility each time a service is rendered. **2.** Clinical and administrative supervision is covered as an indirect cost and part of the rate **3.** Service must not be billed on the same day (except day of admission or discharge) as: Residential levels of care; Other withdrawal management services; Outpatient treatment services; SAIOP; SACOT; ACT; CST; Supported Employment; Psychiatric Rehabilitation; Peer Support Services; Mobile Crisis Management; Partial Hospitalization; Facility Based Crisis (Adult)	Clinical Coverage Policy No: 8A-11, Medically Monitored Inpatient Withdrawal Management Service APSM 45-2 Records Management and Documentation Manuals

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Mobile Crisis Management Code(s): H2011 Triage and Screening is Telehealth Eligible	Mobile Crisis Management (MCM) involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. This service is designed to rapidly assess crisis situations and a member's clinical condition, to triage the severity of the crisis, and to provide immediate, focused crisis intervention services which are mobilized based on the type and severity of crisis.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive)**: **1.** Service Note(s): Required **2.** ASAM: If applicable, the ASAM Score must be supported with detailed clinical documentation on each of the six ASAM dimensions. **3.** Person Centered Plan (PCP) Revision Recommendations: Required for those already receiving services, Mobile Crisis Management (MCM) must recommend revisions to existing crisis plan components in PCPs. **4.** Submission of applicable records that support the member has met the medical necessity criteria. All services are subject to post-payment review.	**Units**: 1 unit = 15 minutes **Age Group**: Children, Adolescents & Adults **Place of Service**: Community settings **Service Specifics, Limitations/ Exclusions (not all inclusive)**: **1.** The crisis management provider must contact the MCO to determine if the member is enrolled with a provider that should be involved with the response. Medicaid shall not cover services when the service unnecessarily duplicates another provider's authorized service. **2.** Service shall be used to divert members from inpatient psychiatric and detoxification services. **3.** Priority should be given to a member with a history of multiple crisis episodes or who are at substantial risk of future crises. **4.** May not be provided concurrently w/: ACT, CST, IIH, MST, MCSART, NMCSART, Withdrawal services, Inpatient services, PRTF (Except on the day of admission for Inpatient & PRTF).	Clinical Coverage Policy No: 8A, Enhanced Mental Health APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Professional Treatment Services in Facility-Based Crisis Program Code(s): S9484	Service provides an alternative to hospitalization for adults (age 18 or older) who have a mental illness or substance use disorder. This can be provided in a non-hospital setting for members in crisis who need short-term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** Service Order: Required and must be ordered by a primary care physician, psychiatrist, or a licensed psychologist. **2.** Service Plan: Required and must be completed at the time the member is admitted to a service. **3.** Progress notes documenting continued stay criteria. **4.** CCA: required prior to discharge in order to document medical necessity. **5.** Submission of applicable records that support the member has met the medical necessity criteria. All services are subject to post-payment review.	**Units**: One unit = 1 hour, up to 24 hours in a 24-hour period. **Age Group**: Adults (age 18 or older) **Place of Service**: Licensed crisis settings **Service Specifics, Limitations/ Exclusions (not all inclusive)**: Provider will arrange for linkage to services for further tx or rehab upon discharge from the Facility Based Crisis Service. Discharge planning begins at the time of admission for all MH and SU services. The step-down process should afford the member a less restrictive level of service without losing the focus of tx or interventions required to facilitate continued progress.	Clinical Coverage Policy No: 8A, Enhanced Mental Health APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates