

Transforming Lives. Building Community Well-Being.

# 2024-2025 Medicaid Acute Behavioral Health Services Benefit Plan

Service Code(s): Services Included (Sorted by Alphabetical Order): Acute and Subacute Services Provided in an Institute for Mental Disease (Non-State Facilities and 160 State ADATCs) Acute and Subacute Services Provided in an Institute for Mental Disease (State Facilities, 160 excluding State ADATCs) T2016 U5, T2016 U6 Behavioral Health Crisis Assessment and Intervention Facility-Based Crisis Service for Children and Adolescents S9484HA Inpatient Behavioral Health Services: Behavioral Health Treatment Milieu Therapy Y2343 Inpatient Behavioral Health Services: Inpatient Hospital Psychiatric Treatment (MH) 100 Inpatient Behavioral Health Services: Medically Managed Intensive Inpatient Services (Using DRG) 100.160 Inpatient Behavioral Health Services: Medically Managed Intensive Inpatient Withdrawal Management 100, 160 Services (Using DRG) Medically Monitored Inpatient Withdrawal Management Service H0010

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.

Member and Recipient Services: 1-877-685-2415





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 Revised: 01-14-2025



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



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



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



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



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



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



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



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



	facility, by submitting a completed <u>Non-Covered State Medicaid</u> <u>Plan Services Request Form</u> 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)
	Description 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		Authorization Parameters         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)	Source(s) Clinical Coverage Policy No: 8A- 11, Medically Monitored Inpatient Withdrawal Management Service APSM 45-2 Records Management and Documentation Manuals
	managed intensive inpatient treatment program.			



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



Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source(s)
Drafagaianal	Service provides an	Pass-Through Period:	Units: One unit = 1 hour, up to 24 hours in a 24-	Clinical Coverage
Professional	alternative to	Prior authorization is not required for	hour period.	Policy No: 8A,
Treatment	hospitalization for adults	this service.		Enhanced Mental
Services in	(age 18 or older) who have a mental illness or	Maintained in the Decard (not all	Age Group: Adults (age 18 or older)	<u>Health</u>
Facility-Based		Maintained in the Record (not all	Place of Complex, Licensed origin acting	
Crisis Program	substance use disorder.	inclusive):	Place of Service: Licensed crisis settings	APSM 45-2
Codo(a): 50494	This can be provided in a	1. Service Order: Required and must	Service Specifics Limitations/Evolutions (not	Records Management and
Code(s): S9484	non-hospital setting for members in crisis who	be ordered by a primary care	Service Specifics, Limitations/ Exclusions (not	Management and
	need short-term intensive	physician, psychiatrist, or a licensed	all inclusive): Provider will arrange for linkage to	Documentation Manuala
		psychologist. <b>2.</b> Service Plan: Required and must	services for further tx or rehab upon discharge from the Facility Based Crisis Service. Discharge	Manuals
	evaluation, treatment intervention or behavioral	be completed at the time the member		PCP Guidance
		is admitted to a service.	planning begins at the time of admission for all MH and SU services. The step-down process	
	management to stabilize acute or crisis situations.	3. Progress notes documenting	should afford the member a less restrictive level of	Documents &
		continued stay criteria.	service without losing the focus of tx or	Templates
			U U U U U U U U U U U U U U U U U U U	
		4. CCA: required prior to discharge in	interventions required to facilitate continued	
		order to document medical necessity.	progress.	
		5. Submission of applicable records		
		that support the member has met the		
		medical necessity criteria.		
		All services are subject to post-		
		payment review.		