To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
2A-3, *Out-of-State Services*
8A, *Enhanced Mental Health and Substance Abuse Services*
8A-1, *Assertive Community Treatment (ACT) Program*
8A-6, *Community Support Team (CST)*

1.0 Description of the Procedure, Product, or Service

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 beneficiaries with acute psychiatric or substance use problems.

a. For beneficiaries with substance use disorder, this service covers:
   1. Medically Managed Intensive Inpatient Services- Adolescent;
   2. Medically Managed Intensive Inpatient Services- Adult; and
   3. Medically Managed Intensive Withdrawal Management Services- Adult.

b. For beneficiaries with mental health disorders, this service covers:
   1. Inpatient Psychiatric Hospitalization- Child and Adolescent; and
   2. Inpatient Psychiatric Hospitalization – Adult.

1.1 Definitions

1.1.1 The American Society of Addiction Medicine (ASAM) Criteria:

The American Society of Addiction Medicine; is a treatment criteria for addictive, substance-related, and co-occurring condition.

1.1.2 Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR):

A tool utilized to assess an individual's alcohol withdrawal.

1.1.3 Medication Assisted Treatment (MAT):

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), '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 beneficiary's needs.'

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(***The term "General" found throughout this policy applies to all Medicaid***

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. **Medicaid**

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. Occasionally, an individual becomes retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible are entitled to receive Medicaid-covered services and to be reimbursed by the provider of all money paid during the retroactive period with the exception of any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services. (Refer to 10A NCAC 22J. 0106.)

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary 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).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services shall be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the

needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs; and
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover Inpatient Behavioral Health Services when the beneficiary meets the specific criteria in **Attachments B, C, and D**.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover services in a freestanding psychiatric hospital for beneficiaries over 21 or less than 65 years of age for mental health disorders.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for Inpatient Behavioral Health Services upon admission through the first 72 hours of service.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Medicaid Beneficiaries

None Apply.

5.2.3 Medicare/Medicaid Dually Eligible Beneficiaries

Prior authorization is not required for Medicare Inpatient Behavioral Health Services rendered to Medicare and Medicaid dually eligible beneficiaries.

5.2.4 Out-of-State Emergency Admissions

Out-of-State emergency admissions do not require prior approval from the PHP, PIHP or UM contractor. In accordance with NC Medicaid clinical coverage policy 2A-3, *Out-of-State Services*, at https://medicaid.ncdhhs.gov/, the provider shall contact the PHP, PIHP or UM contractor, within one business day of the emergency service or emergency admission.

5.3 Utilization Management and Additional Limitations or Requirements

5.3.1 Certificates of Need

a. A Certificate of Need (CON) is required for admission to a freestanding hospital for a Medicaid beneficiary less than 21 years of age or a beneficiary ages 6-18 years old.
b. For Medicaid beneficiaries, the provider shall complete the CON before the date of admission or within 14 calendar days of the date of an emergency admission.-The PHP, PIHP, or UM contractor shall review the submitted by hospital to ensure that signatures of the interdisciplinary teams are complete and timely.
c. For Medicaid beneficiaries, the provider shall maintain a copy of the CON in the beneficiary's health record.
d. Authorization for Medicaid payment begins with the latest signature date on the completed CON form.

5.3.2 Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, equivalent federally recognized tribal code, and as verified by the PIHP or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly effective as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an initial authorization, CCA or DA, service order for medical necessity, the service plan, and the required NC Medicaid authorization request form must be submitted to the PIHP or utilization management contractor within the first 72 hours of service initiation.

Concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. Providers shall submit an updated service plan and any authorization or reauthorization forms required by the PHP, PIHP, or UM contractor.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

The provider shall be licensed by the NC Division of Health Service Regulation under 10A NCAC 27G Section .6000 INPATIENT HOSPITAL TREATMENT FOR INDIVIDUALS WHO HAVE MENTAL ILLNESS OR SUBSTANCE ABUSE DISORDERS unless provided by a 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 asl allowed by §122C-22.(a)(3).

Substance use disorder services can be provided in an Institute of Mental Disease (IMD.)

NC Division of Health Service Regulation
Mental Health Licensure and Certification Section
Refer to https://info.ncdhhs.gov/dhsr/mhlcs/mhpage.html

6.2 Provider Accreditation

The psychiatric hospital or the inpatient program within a general hospital must be accredited by The Joint Commission on Accreditation of Healthcare Organizations.

Providers changing licensure categories or opening a new facility will have one year from Centers for Medicare and Medicaid Services (CMS) certification to achieve accreditation through the Joint Commission.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s). Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with Federal law and regulations.

7.2 Certification of Need for Services

The provider shall certify and recertify a Medicaid beneficiary's need for Inpatient Behavioral Health services in accordance with federal timelines and other requirements in 42 CFR 456.60 and 42 CFR 456.160.

7.3 Plan of Care

The provider shall establish a written individual plan of care for the Medicaid beneficiary.

7.4 Preadmission Authorization and Continued Stay Reviews

a. The PHP, PIHP, or UM contractor conducts initial authorization for continued stay (concurrent) reviews.
b. The provider shall prepare a written utilization review plan for each Medicaid beneficiary in accordance with 42 CFR 456 Subpart D.

7.5 Documentation Requirements

a. Minimum standard is a shift service note that includes:
   1. beneficiary's first and last name and date of birth on each page of the service record;
   2. the date of service;
   3. covered hours for the shift;
   4. the purpose of contact with the beneficiary;
   5. a description of the interventions;
   6. the effectiveness of interventions; and
   7. the signature and credentials of the staff providing the service.
b. In addition, detoxification rating scale tables and flow sheets (including tabulation of vital signs) are used as needed. The provider shall discuss the discharge plan with the beneficiary and document the plan in the health record.
c. An initial assessment must be completed within 72 hours of admission to Inpatient Behavioral Health Services- Medically Managed Intensive Inpatient Services and Medically Managed Intensive Inpatient Withdrawal Management and updated prior to discharge to determine the next clinically appropriate level of care. The initial assessment must include the following documentation in the service record:
   1. a comprehensive nursing assessment, performed at admission;
   2. approval of the admission by a physician;
   3. a comprehensive history and physical examination performed within 12 hours admission, accompanied by appropriate laboratory and toxicology tests;
   4. an addiction-focused history, obtained as part of the initial assessment and reviewed by a physician during the admission process;
   5. a pertinent social, family, and medical history; and
   6. other evaluations or assessments as appropriate.

8.0 Policy Implementation/Revision Information

Original Effective Date: April 1, 2001

Revision Information:

Date	Section Revised	Change
12/01/2005	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/01/2006	Section 2.2	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
05/01/2007	Sections 2 through 4	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
05/01/2007	Attachment A	Added the UB-04 as an accepted claims form.
08/01/2007	Section 6.2	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
07/01/2010	All Sections and Attachments	NCHC: Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/01/2012	All Sections and Attachments	NC Health Choice Program Clinical Coverage Policy Numbers **2009.55** and **2009.56** merged and revised to be equivalent to NC Medicaid Program Clinical Coverage Policy Number 8B pursuant to SL2011-145, Section 10.41(b).
11/01/2012	All Sections and Attachments	Technical changes to merge Medicaid and NCHC current coverage into one policy.
8/1/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
8/1/2014	All Sections and Attachments	Updated: DSM-IV to DSM-5 language, American Society for Addiction Medicine language pertaining to substance use disorder, 2013 CPT codes, language pertaining to intellectual/ developmental disabilities, as well as other technical, nonsubstantive, and clarifying language/grammar changes.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.

Date	Section Revised	Change
12/15/2019	Attachment A	Added: "Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis."
12/15/2019	Attachment A	Added: "Note: North Carolina Medicaid and North Carolina Health Choice shall not reimburse for conversion therapy."
12/15/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/15/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
10/01/2020	Attachment B	Added: "Certified Alcohol and Drug Counselor (CADC)" to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) shall be effective the date the related rule change for 10A NCAC 27G is finalized.
10/01/2020	Attachment B	Added: "Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, the certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) shall be effective the date the related rule for 10A NCAC 27G is finalized."
06/01/2023	Related Clinical Coverage Policies	Added: 8A, Enhanced Mental Health and Substance Abuse Services, 8A-1, Assertive Community Treatment (ACT) Program, and 8A-6, Community Support Team (CST)
06/01/2023	Section 1.0	Added: language clearly defining the substance use and mental health levels of care as well as the ages eligible for each distinct level of care Added: definitions for ASAM, CIWA-Ar, and Medication Assisted Treatment
06/01/2023	Section 3.2.2 thru Section 3.2.9	Moved all admission criteria to the relevant diagnostic sections of Attachments B, C, and D; Removed expired rule from, 10A NCAC 25C .0302, entirely from policy
06/01/2023	Section 5.0	Removed NC Medicaid utilization review and replaced with PHP, PIHP or UM Contractor Updated language regarding unmanaged units and concurrent authorizations

Date	Section Revised	Change
06/01/2023	Section 5.1	Added '72 hour pass through', added language requiring notification of admission to the PHP, PIHP or UM Contractor upon admission
06/01/2023	Section 5.2.1 and 5.2.2	Updated to read 'None apply.'
06/01/2023	Section 5.3	Updated section title to read 'Utilization Management and Additional Limitations and Requirements'
06/01/2023	Section 5.3.2	Removed: 5.3.2 Pending Medicaid Eligibility; added section 5.3.2 Utilization Management
06/01/2023	Section 6.1	Added: under 10A NCAC 27G Section .6000 INPATIENT HOSPITAL TREATMENT FOR INDIVIDUALS WHO HAVE MENTAL ILLNESS OR SUBSTANCE ABUSE DISORDERS unless provided by a IHS or compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t and 1647a. Substance use disorder services can be provided in an Institute of Mental Disease (IMD.) NC Division of Health Service Regulation Mental Health Licensure and Certification Section Refer to https://info.ncdhhs.gov/dhsr/mhlcs/mhpage.html Moved language regarding licensure requirements from Section 6.1 to Section 6.2- Provider Accreditation
06/01/2023	Section 6.2	Added language addressing providers changing licensure categories
06/01/2023	Section 7.1 b.	Added 'Federally recognized tribal and Indian Health Service providers may be exempt to one or more of these items in accordance with Federal law and regulations.'
06/01/2023	Section 7.5	Removed 'for 8 hours of services provided', listed required components of documentation in bulleted format. Removed 'Refer to Attachment B for service specific requirements', Added guidance regarding initial assessment requirements
06/01/2023	Attachment A	Added 'Federally recognized tribal and Indian Health Service providers may be exempt to one or more of these items in accordance with Federal law and regulations.'

Date	Section Revised	Change
06/01/2023	Attachment B	Removed Level 4-WM, added 'Withdrawal Management' and ASAM Level 4-WM Added language requiring providers to either initiate or sustain any MAT the beneficiary needs to support their recovery from substance use Changed 'physician' to 'non-psychiatric physician' Clarified that CCS or LCAS are responsible for supervising the clinical care provided Added clarifying language from the 2013 ASAM Criteria regarding required components for an Medically Managed Intensive Inpatient Withdrawal Management Services Added requirements for physicians and psychiatrists, nursing staff, and clinical staff in Staffing Requirements Added allowance for this service to be provided in an Institute of Mental Disease in Service Type or Setting Removed NC Medicaid utilization review and replaced with PHP, PIHP or UM Removed language stating initial authorization is limited to seven calendar days. Updated Entrance Criteria to reflect 2013 ASAM Criteria Deleted initial assessment requirements, moved to section 7.5 Replaced Person Centered Plan with treatment plan Revised Continued Stay Criteria, combining letter e. with letter d. Revised Discharge Criteria section to address Transition and Discharge Criteria, clarified transition and discharge criteria Added 'stabilization of withdrawal signs and symptoms' to Expected Outcomes Removed 'for every 8 hours of services provided' in Documentation Requirements Revised Service Exclusions or Limitations from paragraph format to bullet list Removed three examples of when 'Services are not covered', removed language addressing initial authorization, continuing authorization, and Certificate of Need and moved it to Section 5.0
06/01/2023	Attachment C	Added new attachment for Medically Managed Intensive Inpatient Services, ASAM Level 4

Date	Section Revised	Change
06/01/2023	Attachment D	Removed 'his', replaced with 'their' Changed 'physician' to 'non-psychiatric physician Removed 'prior to' and replaced with 'before' Replaced 'face-to-face' with 'in-person' Replaced 'medical' with 'physical health' Removed 'Statewide vendor' and replaced with 'PHP, PIHP or UM contractor' Deleted language regarding initial authorization being limited to 72 hours Moved 'Symptoms are not due solely to intellectual disability' from Continued Stay Criteria to Entrance Criteria Added I. Entrance Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21-64 only, re-ordered subsequent sections Section J- replaced 'three calendar days' with '72 hours', revised this section to remove duplicative statements and to better clarify what the continued stay criteria is Section L- Clarified this section addresses Continued Stay Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21-64 only Updated Section I to address Transfer and Discharge Criteria Removed 'will' and replaced with Shall Removed 'for every 8 hours of services provided' in Documentation Requirements, added 'coverage hours for the shift'
06/01/2023		Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.
12/15/2023		Fixed minor formatting issue posting and amended date not changed.
01/01/2025	Subsection 5.3.2	Revised "PCP" to "service plan" for concurrent review requirements. Revised "LME-MCO" to "PHP, PIHP, or UM contractor."

Date	Section Revised	Change
01/01/2025	Attachment B	Effective 01/01/2024, 10A NCAC 27G Staff Definitions amended. Removed references to Certified Substance Abuse Counselor (CSAC). Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, the certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) shall be effective the date the related rule for 10A NCAC 27G is finalized. To comply with the Mental Health Parity and Addiction Equity Act and the Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900, removed requirement that utilization review must be conducted every 7 calendar days. Added: "to determine ongoing medical necessity" and "beneficiary" to sentence, "The provider shall conduct utilization review [to determine ongoing medical necessity] and document it in the treatment plan and the service record [of the beneficiary].
01/01/2025	Attachment C	Effective 01/01/2024, 10A NCAC 27G Staff Definitions amended. Removed references to Certified Substance Abuse Counselor (CSAC). Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, the certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) shall be effective the date the related rule for 10A NCAC 27G is finalized. To comply with the Mental Health Parity and Addiction Equity Act and the Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900, removed requirement that utilization review must be conducted every 10 calendar days. Added: "to determine ongoing medical necessity" and "beneficiary" to sentence, "The provider shall conduct utilization review [to determine ongoing medical necessity] and document it in the treatment plan and the service record [of the beneficiary].
01/01/2025	Attachment D	Added: "beneficiary" to sentence, "For Medicaid, utilization review must be conducted every 72 hours for non-state operated facilities and is documented in the treatment plan and the service record [of the beneficiary].
01/01/2025	Subsection 5.3.2	Added "equivalent federally recognized tribal code" to the second paragraph.
01/01/2025	Attachment A: Claims-Related Information	F. Place of Service - added "or equivalent federally recognized tribal code or operated by Indian Health Services".

Date	Section Revised	Change
01/01/2025	Attachment B: Medically Managed Intensive Inpatient Withdrawal Management Services, Letter (B.)	Added “or equivalent federally recognized tribal code or be an Indian Health Service Provider” to the first paragraph.
01/01/2025	Attachment B: Medically Managed Intensive Inpatient Withdrawal Management Services, Letter (C.)	Added “or equivalent federally recognized tribal code or be an Indian Health Service Regulations” to the third and fourth paragraph.

Attachment A: Claims-Related Information

Provider(s) shall comply with the *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid. Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Providers shall bill applicable revenue codes.

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10-CM edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Medical, psychiatric, and substance abuse therapeutic interventions are reimbursed at a per diem rate based on occupancy on the inpatient unit during midnight bed count. Federally recognized tribal or HIS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service

Inpatient Behavioral Health services are covered in a hospital as defined in G.S. 131E-176(13) or equivalent federally recognized tribal code or operated by Indian Health Services.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/
Physician and other professional time not included in the daily rate are billed separately.

Note: North Carolina Medicaid and North Carolina Health Choice ~~will~~ shall not reimburse for conversion therapy.

Attachment B: Medically Managed Intensive Inpatient Withdrawal Management Services (Using DRG)

ASAM Level 4WM

A. Service Definition and Required Components

Medically Managed Intensive Inpatient Withdrawal Management Service is an organized service delivered by medical and nursing professionals that provides 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols. This is an American Society of Addiction Medicine (ASAM) Level 4-WM for adult beneficiaries 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 beneficiary can be safely managed at a less intensive level of care. This level of care must be capable of initiating or continuing any MAT that supports the beneficiary in their recovery from substance use.

A service order for Medically Managed Intensive Inpatient Withdrawal Management Services must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice before or on the day that the services are to be provided.

B. Provider Requirements

Medically Managed Intensive Inpatient Withdrawal Management Services must be delivered by an interdisciplinary team comprised of addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers and other appropriately credentialed treatment professionals employed by an organization that meets the provider qualification policies, procedures, and standards established by Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the requirements of 10A NCAC 27G or equivalent federally recognized tribal code or be an Indian Health Service Provider. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.

Medically Managed Intensive Inpatient Withdrawal Management Services must be delivered in a licensed 24-hour inpatient setting or in State operated facilities where medical management is provided by physicians 24 hours a day, primary nursing care and observation is provided 24 hours a day, and professional counseling services are available and provided eight (8) hours a day. This service may be provided at an acute care general hospital, an acute care psychiatric hospital, a psychiatric unit within an acute care general hospital, or a licensed addiction treatment specialty hospital with acute care medical and nursing staff, or in State Operated Healthcare Facilities. A psychiatric hospital or an inpatient program in a hospital shall be accredited in accordance with 42 CFR 441.151(a)(2).

C. Staffing Requirements

Medically Managed Intensive Inpatient Withdrawal Management Services are staffed by non-psychiatric physicians and psychiatrists who are available 24 hours a day by telephone, conduct assessments within 24 hours of admission, and are active members of an interdisciplinary team of appropriately trained professionals, and who medically manage the care of the beneficiary. A

registered nurse is available for primary nursing care and observation 24 hours per day. Clinical staffing must be in place to ensure that professional counseling services are available and provided at a minimum of eight hours a day. Staffing must be sufficient to ensure that monitoring is completed based on medical and clinical need. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders.

Support systems must include availability of specialized medical consultation, full medical acute care services, and intensive care, as needed. These services are designed to treat the beneficiary's level of clinical severity and to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the beneficiary's transition into ongoing treatment and recovery. Persons who meet the requirements specified for Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialty (LCAS), and Alcohol and Drug Counselor (CADC) under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Withdrawal Management Substance Use Services. The planned regimen of 24-hour clinical evaluation and treatment services must be under the supervision of a CCS or LCAS who is available by phone 24 hours a day. The CCS, LCAS, CADC must be available eight hours a day to administer planned interventions according to the assessed needs of the beneficiary.

The planned regimen of 24-hour evaluation care and treatment services, for patients engaged in Medically Managed Intensive Inpatient Withdrawal Management Substance Use Services may also be provided by staff who meet the requirements specified for:

a. Qualified Professional (QP);
b. Associate Professional (AP) status in Substance Abuse according to 10A NCAC 27G .0104, under the supervision of a LCAS or CCS;
c. equivalent federally recognized tribal code; or
d. be an Indian Health Service Regulations.

Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G .0104 or equivalent federally recognized tribal code or be an Indian Health Service Regulations and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Withdrawal Management Services, under the supervision of a LCAS or CCS.

Note: Per 25 USC 1621t "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and education Assistance Act (25 U.S.C. 450 et seq.)."

D. Service Type or Setting

Services shall be provided in a licensed 24-hour inpatient setting. 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 Institute of Mental Disease (IMD.)

E. Utilization Management

Authorization by the PHP, PIHP, or UM contractor is required for concurrent reviews.

F. Entrance Criteria

The following criteria are to be utilized for review for psychiatric treatment of a beneficiary aged 18 and older with a substance use disorder(s):

1. Any DSM-5, or any subsequent editions of this reference material, diagnosis of substance use, and
2. Meets American Society of Addiction Medicine (ASAM) Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management Services.

G. Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's treatment plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

a. The beneficiary has achieved initial treatment plan goals and these services are needed to meet additional goals.
b. Beneficiary is making satisfactory progress toward meeting goals.
c. The beneficiary is making some progress, but the treatment plan (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved.
d. The beneficiary is not making progress or regressing; the treatment plan must be modified to identify more effective interventions.

The provider shall conduct utilization reviews to determine ongoing medical necessity and document it in the treatment plan and the service record of the beneficiary.

H. Transfer and Discharge Criteria

The beneficiary meets the criteria for transition and discharge if any one of the following applies:

a. Beneficiary has achieved goals articulated in the treatment plan, thus resolving the symptom(s) that justified admission to the present level of care; and continuing the chronic disease management of the beneficiary's condition at a less intensive level of care is indicated; or
b. Beneficiary has been unable to resolve the symptom(s) that justified admission to the present level of care, or symptom(s) have intensified despite amendments to the treatment plan, and an updated CCA or DA indicates transfer to a different level is needed; or
c. Beneficiary has demonstrated a lack of progress due to diagnostic or co-occurring conditions that limit the ability to alleviate the beneficiary's symptoms(s), and an updated assessment indicates transfer to a different level of care is needed; or
d. A beneficiary or legally responsible person no longer wishes to receive Inpatient Behavioral Health Services.

I. Expected Outcomes

The expected outcome of this service is the establishment of abstinence and the stabilization of withdrawal signs and symptoms sufficient to enable a transfer to a less restrictive level of care.

J. Documentation Requirements

Minimum standard is a shift service note that includes the beneficiary's full name, birth date, date of service, coverage hours for the shift, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature and credentials of the staff providing the service. In addition, detoxification rating scale tables and flow sheets (including tabulation of vital signs) are used as needed. The provider shall discuss the discharge plan with the beneficiary and document the plan in the health record.

K. Service Exclusions or Limitations

The non-duplicative components (case management) of the following services can be provided to beneficiaries being admitted to or discharged from Medically Managed Intensive Inpatient Withdrawal Management Service:

a. Intensive In-Home Services;

b. Multisystemic therapy;

c. Community Support Team;

d. Assertive Community Treatment;

e. Substance Abuse Intensive Outpatient; and

f. Substance Abuse Comprehensive Outpatient.

Support provided should be delivered in coordination with the Medically Managed Intensive Inpatient Withdrawal Management Substance Use provider and be documented in the treatment plan. Discharge planning shall begin upon admission to the service.

Attachment C: Medically Managed Intensive Inpatient Services (Using DRG)

ASAM Level 4

A. Service Definition and Required Components

Medically Managed Intensive Inpatient Service is an organized service delivered in an acute care inpatient setting. This service encompasses a regimen of medically directed evaluation and treatment services, provided in a 24-hour treatment setting, under a defined set of policies, procedures, and individualized clinical protocols. This is an American Society of Addiction Medicine (ASAM) Level 4 for adolescent and adult beneficiaries 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. This level of care must be capable of initiating or continuing any MAT that supports the beneficiary in their recovery from substance use.

When serving adolescents beneficiaries in Medically Managed Intensive Inpatient Services, the facility must be able to provide withdrawal management services that address the physiological and psychological symptoms, and also address the process of interrupting the momentum of habitual compulsive use in adolescents diagnosed with high-severity substance use disorder. This level of treatment shall require a greater intensity of service initially in order to establish treatment engagement and beneficiary role induction.

A service order for Medically Managed Intensive Inpatient Services must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice before to or on the day that the services are to be provided.

B. Provider Requirements

Medically Managed Intensive Inpatient Services for adolescents and adults must be delivered by an interdisciplinary team comprised of addiction-credentialed physicians and other appropriately credentialed treatment professionals employed by an organization that meets the provider qualification policies, procedures, and standards established by Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.

Medically Managed Intensive Inpatient Services for adolescents and adults must be delivered in a licensed 24-hour inpatient setting or in State operated facilities. This service may be provided at an acute care general hospital, an acute care psychiatric hospital, a psychiatric unit within an acute care general hospital, or a licensed addiction treatment specialty hospital with acute care medical and nursing staff, or in a State operated psychiatric hospital. A psychiatric hospital or an inpatient program in a hospital shall be accredited in accordance with 42 CFR 441.151(a)(2).

C. Staffing Requirements

Medically Managed Intensive Inpatient Services for adolescents and adults are staffed by non-psychiatric physicians, psychiatrists, physician extenders, and nurse practitioners who medically manage the care of the beneficiary. A physician shall be available 24 hours a day by telehealth or telephone. A registered nurse is available for nursing assessments, primary nursing care and observation 24 hours per day. Professional clinical counseling services are available a minimum of 16 hours a day. Staffing must be sufficient to ensure that monitoring is completed based on medical and clinical need. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders.

When serving adolescents in Medically Managed Intensive Inpatient Services, the interdisciplinary team shall have medical or clinical experience working with adolescents diagnosed with a substance use disorder.

Support systems must include availability of specialized medical consultation, full medical acute care services, and intensive care, as needed. These services are designed to treat the beneficiary's level of clinical severity and to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the beneficiary's transition into ongoing treatment and recovery. Persons who meet the requirements specified for Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialty (LCAS), or Certified Alcohol and Drug Counselor (CADC) under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Services. The planned regimen of 24-hour clinical evaluation and treatment services must be under the supervision of a CCS or LCAS who is available by phone 24 hours a day. A CCS, LCAS, CADC must be available 16 hours a day to administer planned interventions according to the assessed needs of the beneficiary.

The planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Services may also be provided by staff who meet the requirements specified for Qualified Professional (QP) or Associate Professional (AP) status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a LCAS or CCS.

When working with adolescents in Medically Managed Intensive Inpatient Services, the interdisciplinary team shall offer daily clinical services to assess the adolescent beneficiary's withdrawal status and provide treatment as needed. Clinical services involve medical management and individual or group therapy specific to withdrawal and withdrawal support. Frequent nurse monitoring of the adolescent beneficiary's progress in withdrawal management is available, and medication administration is available as needed.

Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Services, under the supervision of a LCAS or CCS.

All staff providing Medically Managed Intensive Inpatient Services to adolescents shall have direct experience working with adolescents diagnosed with a substance use disorder and shall receive continuing education and training specific to this population annually.

Note: Per 25 USC 1621t "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and education Assistance Act (25 U.S.C. 450 et seq.)."

D. Service Type or Setting

Services provided in a licensed 24-hour inpatient setting. 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 Institute of Mental Disease (IMD.)

L. Utilization Management

Authorization by the PHP, PIHP, or UM contractor is required.

E. Entrance Criteria

Beneficiaries shall meet all the criteria below to be approved for admission:

1. The beneficiary shall meet criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material, substance use disorder diagnosis, and
2. The beneficiary shall meet the criteria for ASAM level 4- Medically Managed Intensive Inpatient Services.

F. Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's treatment plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

1. Beneficiary has achieved initial treatment plan goals and these services are needed to meet additional goals,
2. Beneficiary is making satisfactory progress toward meeting goals,
3. Beneficiary is making some progress, but the treatment plan (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved, or
4. The beneficiary is not making progress or regressing; the treatment plan must be modified to identify more effective interventions.

The provider shall conduct utilization reviews to determine ongoing medical necessity and document the treatment plan and service record of the beneficiary.

G. Transfer and Discharge Criteria

The beneficiary meets the criteria for transition and discharge if any one of the following applies:

a. Beneficiary has achieved goals articulated in the treatment plan, thus resolving the symptom(s) that justified admission to the present level of care; and continuing the

chronic disease management of the beneficiary's condition at a less intensive level of care is indicated;

b. Beneficiary has been unable to resolve the symptom(s) that justified admission to the present level of care, or symptom(s) have intensified despite amendments to the treatment plan, and an updated CCA or DA-indicates transfer to a different level is needed;
c. Beneficiary has demonstrated a lack of progress due to diagnostic or co-occurring conditions that limit the ability to alleviate the beneficiary's symptoms(s), and an updated assessment indicates transfer to a different level of care is needed; or
d. A beneficiary or legally responsible person no longer wishes to receive Inpatient Behavioral Health Services.

H. Expected Outcomes

The expected outcome of this service is the establishment of abstinence sufficient to enable a transfer to a less restrictive level of care, and development and implementation of a care coordination focused plan to ensure transition to the next clinically appropriate level of care.

I. Documentation Requirements

Minimum standard is a shift service note that includes the beneficiary's full name, birth date, date of service, coverage hours for the shift, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature and credentials of the staff providing the service. In addition, detoxification rating scale tables and flow sheets (including tabulation of vital signs) are used as needed. The provider shall discuss the discharge plan with the beneficiary and document the plan in the health record.

J. Service Exclusions or Limitations

The non-duplicative components, for example case management, of the following services can be provided to beneficiaries being admitted to or discharged from Medically Managed Intensive Inpatient Service for adolescents and adults:

1. Intensive In-Home Services;
2. Multisystemic Therapy;
3. Community Support Team;
4. Assertive Community Treatment;
5. Substance Abuse Intensive Outpatient;
6. Substance Abuse Comprehensive Outpatient; and
7. Child and Adolescent Day Treatment.

The support provided should be delivered in coordination with the Inpatient Substance Abuse Hospital provider and be documented in the treatment plan. Discharge planning shall begin upon admission to the service.

Attachment D: Inpatient Hospital Psychiatric Treatment (MH)

Billable Service

A. Service Definition and Required Components

Inpatient Hospital Psychiatric Service 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 beneficiaries with acute psychiatric problems.

A service order for Inpatient Hospital Psychiatric Service must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice before or on the day that the services are to be provided.

B. Provider Requirements

Inpatient Hospital Psychiatric Services must be delivered in a licensed 24-hour inpatient setting or in State operated facilities. This service may be provided at a psychiatric hospital or on an inpatient unit within a licensed hospital or in State Operated Healthcare Facility. A psychiatric hospital or an inpatient program in a hospital must be accredited in accordance with 42 CFR 441.151(a)(2), 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).

C. Staffing Requirements

Inpatient Hospital Psychiatric Services are staffed by non-psychiatric physicians and psychiatrists, who are available 24 hours a day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration on an ongoing basis. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a psychiatrist who is available by phone 24 hours a day.

Note: Per 25 USC 1621t "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and education Assistance Act (25 U.S.C. 450 et seq.)."

D. Service Type or Setting

The service is provided in a licensed 24-hour inpatient setting. 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. A psychiatric hospital or an inpatient program in a hospital **shall be accredited in accordance with 42 CFR 441.151(a)(2),** 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).

E. Program Requirements

This service focuses on reducing acute psychiatric symptoms through in-person, structured group and individual treatment. This service is designed to offer physical health psychiatric and therapeutic interventions including such treatment modalities as medication management, psychotherapy, group therapy, dual diagnosis treatment for comorbid psychiatric and substance use disorders and milieu treatment; medical care and treatment as needed; and supportive services including room and board. A determination of the appropriate services is made by the care provider under the direction of the attending physician. These services are reimbursed at a per diem rate based on occupancy on the inpatient unit during the midnight bed count. Physician and other professional time not included in the daily rate is billed separately.
Educational services are not billable to Medicaid but must be provided according to state and federal educational requirements.

F. Utilization Management

Authorization by the PHP, PIHP, or UM contractor is required.

G. Certification of Need Process

For Medicaid, a CON process is necessary for beneficiaries less than 21 years of age.

The CON process must be performed by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the beneficiary's situation.

For Medicaid, when an individual who applies for Medicaid while in the facility or program, the CON must be performed by the team responsible for the plan of care and cover any period before the application date for which the facility is seeking to have Medicaid coverage begin.

The provider shall certify and recertify a Medicaid beneficiary's need for Inpatient Behavioral Health services in accordance with federal timelines and other requirements in 42 CFR 456.60 and 42 CFR 456.160.

H. Entrance Criteria for Inpatient Psychiatric Hospital Treatment Admission for a Medicaid Beneficiary less than 21 years of age.

Medicaid criteria for the admission of a beneficiary less than 21 years of age to psychiatric hospitals or psychiatric units of general hospitals limited herein. Beneficiaries shall meet all the criteria below to be approved for admission:

The beneficiary shall meet criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material, diagnosis, and at least one of the following:

1. A beneficiary is presently a danger behavior or include- engages in self-injurious behavior, a severe potential for self-injurious behavior, or is acutely manic. This usually would be indicated by one of the following:
    a. Beneficiary has made a suicide attempt or serious gesture (can include- overdose, hanging, jumping from or placing self in front of moving vehicle, self-inflicted gunshot wound), or is threatening same with likelihood of acting on the threat, and there is an absence of supervision or structure to prevent suicide of the beneficiary who has made an attempt, serious gesture or threat; or

b. Beneficiary manifests a severe depression, including current contemplation of suicide or suicidal ideation, and there is an absence of supervision or structure to prevent suicide; or
c. Beneficiary has a history of affective disorder:
    i. With mood which has fluctuated to the manic phase,
    ii. Has destabilized due to stressors or non-compliance with treatment; or
    iii. A beneficiary is exhibiting self-injurious behavior (can include- cutting on self, burning self) or is threatening same with likelihood of acting on the threat.
d. A beneficiary engages in actively violent, aggressive, or disruptive behavior or beneficiary exhibits homicidal ideation or other symptoms which indicate the beneficiary is a probable danger to others. This usually would be indicated by one of the following:
    i. Beneficiary whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgement, severe oppositional behavior, running away, severely disruptive behaviors at home or school, self-defeating and self-endangering activities, antisocial activity, and other behaviors which may occur in the context of a dysfunctional family and may also include physical, psychological, or sexual abuse; or
    ii. Beneficiary exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (can include- assaults with or without weapons, provocations of fights, gross aggressive over-reactivity to minor irritants, harming animals or is threatening same with likelihood of acting on the threat). This behavior should be attributable to the beneficiary's specific DSM-5, or any subsequent editions of this reference material, diagnosis and can be treated only in a hospital setting.
e. Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the beneficiary unmanageable and unable to cooperate in treatment. This usually would be indicated by the following: beneficiary has recent onset or aggravated psychotic symptoms (can include- disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous speed, severely impaired judgment) and is resisting treatment or is in need of assessment in a safe and therapeutic setting; or
f. Presence of medication needs, or a medical process or condition, which is life threatening (can include- toxic drug level) or which requires the acute care setting for its treatment. This usually would be indicated by one of the following:
    i. Proposed treatments require close medical observation and monitoring to include, but not limited to, close monitoring for adverse medication effects, capacity for rapid response to adverse effects, and use of medications in clients with concomitant serious medical problems; or
    ii. Beneficiary has a severe eating disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
g. Need for medication therapy or complex diagnostic evaluation where the beneficiary's level of functioning precludes cooperation with the treatment regimen, including forced administration of medication. This usually would be indicated by one of the following:
    i. Beneficiary whose diagnosis and clinical picture is unclear and who requires 24-hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.

ii. Beneficiary is involved in the legal system (can include- in a detention or training school facility) and manifests psychiatric symptoms (can include- psychosis, or depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

h. Symptoms are not due solely to intellectual disability; and

i. A provider team shall certify that the beneficiary meets each of the certification of need requirements listed at 42 CFR 411. 152.

I. Entrance Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21–64 only

The following is entrance criteria for psychiatric treatment of adult non-substance use disorders and all other conditions:

Any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following:

1. Impaired reality testing (e.g., delusions, hallucinations), disordered behavior or other acute disabling symptoms not manageable by alternative treatment;
2. Potential danger to self or others and not manageable by alternative treatment;
3. Concomitant severe medical illness or substance use disorder necessitating inpatient treatment;
4. Severely impaired social, familial, occupational, or developmental functioning that cannot be effectively evaluated or treated by alternative treatment;
5. Failure of or inability to benefit from alternative treatment, in the presence of severe disabling psychiatric illness;
6. Need for skilled observation, special diagnostic or therapeutic procedures or therapeutic milieu necessitating inpatient treatment; or
7. Symptoms are not due solely to intellectual disability.

J. Continued Stay Criteria for Inpatient Psychiatric Hospital Admission for a Medicaid Beneficiary less than 21 years of age.

After an initial admission period of up to 72 hours, the Medicaid beneficiary shall meet each of the conditions:

A current DSM-5, or any subsequent editions of this reference material, diagnosis and current symptoms or behaviors which are characterized by all of the following:

1. Symptoms or behaviors are likely to respond positively to acute inpatient treatment; and
2. Symptoms or behaviors are not characteristic of patient's baseline functioning; and
3. Presenting problems are an active exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change:
   a. Beneficiary is not making progress or regressing, and the treatment plan must be modified to identify more effective interventions; or
   b. Beneficiary is making some progress and further treatment gains could be achieved, and the treatment plan must be modified to identify more effective interventions; and
   c. The symptoms of the beneficiary are characterized by at least one of the following:

4. Endangerment of self or others;
5. Behaviors which are grossly bizarre, disruptive, and provocative (can include- feces smearing, disrobing, pulling out hair); or
6. Related to repetitive behavior disorders which present at least five times in a 24-hour period; or
7. Directly result in an inability to maintain age-appropriate roles:
    a. The symptoms of the beneficiary are characterized by a degree of intensity sufficient to require continual medical or nursing response, management, and monitoring; and
    b. The services provided in the facility can reasonably be expected to improve the beneficiary's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the beneficiary's psychiatric condition required services on an inpatient basis under the direction of a physician.

K. For Medicaid beneficiaries only: 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 beneficiaries 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 beneficiary's treatment needs and provided that all of the following conditions are met:

1. The psychiatric facility providing continued stay has made a referral for Care Coordination and after care services to PHP, PIHP, or UM contractor, which serves the beneficiary's county of eligibility.
2. The PHP, PIHP, or UM contractor and the psychiatric facility have agreed that the beneficiary has a history of sudden decompensation or measurable regression, and experiences weakness in his or her environmental support system which is likely to trigger a decompensation or regression. This history must be documented by the beneficiary's attending physician.
3. The PHP, PIHP, or UM contractor shall approve Medicaid for continued stay based on criteria in **Subsection 3.2.4.**
4. The psychiatric facility providing continued stay at a post-acute level of care shall file claims for Medicaid reimbursement.

For Medicaid, utilization review must be conducted every 72 hours for non-state operated facilities and is documented in the treatment plan and service record of the beneficiary.

L. Continued Stay Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21-64 only

The criteria for continued stay in an acute inpatient psychiatric facility are summarized below:

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the treatment plan and the beneficiary continues to be at risk of harming self or others as evidenced by direct threats or clear and reasonable inference of serious harm to self-violent, unpredictable or uncontrollable behavior which represents potential for serious harm to the person or property of others; demonstrating inability to adequately care for own physical

needs; or requires treatment which is not available or is unsafe on an outpatient basis. The beneficiary's condition must require psychiatric and nursing interventions on a 24-hour basis.

M. Transfer and Discharge Criteria

The beneficiary meets the criteria for transition and discharge if any one of the following applies:

1. Beneficiary has achieved goals articulated in the treatment plan, thus resolving the symptom(s) that justified admission to the present level of care; and continuing the chronic disease management of the beneficiary's condition at a less intensive level of care is indicated; or
2. Beneficiary has been unable to resolve the symptom(s) that justified admission to the present level of care, or symptom(s) have intensified despite amendments to the treatment plan, and an updated CCA or DA indicates transfer to a different level is needed; or
3. Beneficiary has demonstrated a lack of progress due to diagnostic or co-occurring conditions that limit the ability to alleviate the beneficiary's symptoms(s), and an updated assessment indicates transfer to a different level of care is needed; or
4. A beneficiary or legally responsible person no longer wishes to receive Inpatient Behavioral Health Services.

N. Expected Outcomes

The beneficiary shall attain a level of functioning including stabilization of psychiatric symptoms and establishment of abstinence sufficient to allow for subsequent substance use disorder or mental health treatment in a less restrictive setting.

O. Documentation Requirements

Minimum standard is a shift note that includes the beneficiary's full name, birth date, date of service, coverage hours for the shift purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

P. Service Exclusions/Limitations

The non-duplicative components, for example case management, of the following services can be provided to beneficiaries being admitted to or discharged from Inpatient Hospital Psychiatric Treatment for adolescents and adults:

1. Intensive In-Home Services;
2. Multisystemic therapy;
3. Community Support Team;
4. Assertive Community Treatment;
5. Substance Abuse Intensive Outpatient;
6. Substance Abuse Comprehensive Outpatient;
7. Child and Adolescent Day Treatment.

Services must be delivered in coordination with the Inpatient Hospital Psychiatric provider and be documented in the treatment plan. Discharge Planning shall begin upon admission to this service.