

Transforming Lives. Building Community Well-Being.

# 2024-2025 Medicaid Acute Behavioral Health Services Benefit Plan

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

Codes / modifier combinations not mentioned for specialized services will be found within contracts.

For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.

When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.





S9484 <u>Professional Treatment Services in Facility-Based Crisis Program</u>



#### **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

Revised: 10-01-2024



#### 2024-2025 Medicaid Acute BH Service Benefit Plan

#### 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.

Service & Code	Brief Service Description	Auth Submission 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	Behavioral Health
Provided in	intensive	Initial Requests (after pass-	exceed 15 days, but no more than 15 days may be authorized in	Services
an Institute	evaluation and	through):	each month. There is not a day limit for members receiving SU	
for Mental	treatment	1. TAR: prior authorization required	services.	July 2012 MCD
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.	<u>Authorization</u>
( <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	<u>Psychiatric</u>
<u>State</u>	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.	<u>Care</u>
	disorders. Delivery	this requirement.		<u>Providers</u>
Code(s): 160	of service is	3. Service Order: Required, signed	<u>Units</u> : Per diem based on the midnight bed count	105 // 10==
	provided by	by a physician, LP, PA, or NP. A		JCB #J277:
	nursing and	signed H&P/ Initial Psychiatric Eval	Age Group: Adults aged 21-64	Authorization
	medical	meets this requirement.	Place of Complex Institute for Montal Disease (IMD)	Requests for
	professionals	4. Service Plan: Required	Place of Service: Institute for Mental Disease (IMD)	Services When a
	under the	5. Submission of all records that	Service Specifica Limitational Evaluaiona (not all inclusiva)	Third-Party Payer
	supervision of a	support the individual has met the	Service Specifics, Limitations/ Exclusions (not all inclusive):  1. The case management component of IIH, MST, CST, ACT,	<u>is Primary</u>
	psychiatrist. Providers must	medical necessity criteria.	SAIOP, SACOT & CADT can be provided to those admitted to or	JCB #J265:
	follow the	Reauthorization Reguests:	discharged from this service. Support provided should be delivered	Clarification of
	requirements for	1. TAR: prior authorization required.	in coordination with the Inpatient facility.	Services in an
	inpatient level of	2. Updated Tx Plan/ PCP: Required	2. Medicaid eligibility must be verified each time a service is	IMD
	care outlined in	3. Submission of applicable records	rendered.	IIVID
	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.	4. Prior authorization is not required for MCD BH Services rendered	IMD Clarification
	Inpatient	and meanan measuring ememan	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 Requirements	Authorization Parameters	Source(s)
	This is an organized	Initial Requests:	Length of Stay:	Clinical Coverage
Acute and	service that provides	1. TAR: Required	1. Provider must submit a TAR covering the member's length of	Policy No: 8-B,
Subacute	intensive evaluation	2. I/DD Exception Form:	stay on the next business day following the Individual's	<u>Inpatient</u>
Services Provided	and treatment	Required per Diversion Law, if	discharge.	Behavioral Health
in an Institute for	delivered in an acute	applicable.	2. Member's that present directly to the facility as an emergency	<u>Services</u>
Mental Disease	care inpatient setting	3. CCA or DA: Required. See	commitment or as a self-referral, the facility shall submit a TAR	
	by medical and	CCP Section 7.5 for additional	by the next business day.	July 2012 MCD
(State Facilities,	nursing	requirements. An H&P/ Initial	3. Members receiving tx for MH diagnoses are limited to no more	Bulletin:
excluding State	professionals. This	Psychiatric Evaluation may	than 15 authorized days each calendar month. For admissions	Authorization
<u>ADATCs</u> )	service focuses on	meet this requirement.	spanning two consecutive months, the total length of stay may	Requests by
0 1 ( ) 400	reducing acute	4. Service Order: Required,	exceed 15 days, but no more than 15 days may be authorized in	<u>Psychiatric</u>
Code(s): 160	psychiatric	signed by a physician, LP, PA,	each month. There is not a day limit for members receiving SU	Inpatient Acute
	symptoms through	or NP. A signed H&P/ Initial	services.	<u>Care</u>
	in-person, structured	Psychiatric Eval meets this	United A south new days for son to AE days new month	<u>Providers</u>
	group and individual	requirement.	<u>Units</u> : 1 unit per day for up to 15 days per month.	ICD # 1277.
	treatment.	<ul><li>5. Service Plan: Required</li><li>6. Submission of all records</li></ul>	Age Group: Adults aged 21-64	JCB #J277: Authorization
		that support the member has	Age Group. Addits aged 21-04	Requests for
		met the medical necessity	Place of Service: Institute for Mental Disease (IMD)	Services When a
		criteria. The state facility shall	Tiace of Service. Institute for Merital Disease (IMD)	Third-Party Payer
		provide Trillium with all	Service Specifics, Limitations/ Exclusions (not all inclusive):	is Primary
		necessary clinical information	Trillium will issue an auth decision within 14 days after receipt	<u>is i filliary</u>
		needed for the utilization	of the TAR.	JCB #J265:
		management process.	2. The case management component of IIH, MST, CST, ACT,	Clarification of
		management processi	SAIOP, SACOT & CADT can be provided to those admitted to or	Services in an
		Reauthorization Requests:	discharged from this service. Support provided should be	IMD
		Not applicable	delivered in coordination with the Inpatient facility.	<del></del>
			3. Medicaid eligibility must be verified each time a service is	JCB #J348: SUD
			rendered.	IMD Clarification
			<b>4.</b> Discharge Planning shall begin upon admission to this service.	
			5. Prior authorization is not required for MCD BH Services	APSM 45-2
			rendered to Medicare/Medicaid dual eligible members or	Records
			members with 3rd-party insurance because MCD is the payer of	Management and
			last resort. When MCD becomes the primary payer, a primary	<u>Documentation</u>
			payer auth denial/ exhaustion of benefits letter is submitted with	<u>Manuals</u>
			the MCD TAR.	



Service & Code	Brief Service Description	Auth Submission 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	1. Tier IV BHUC holds IVC designation and		Service Definition
Intervention	Care (BHUC) setting for	completes IVC First Evaluations.	Individuals receiving this service will be	
(BH-CAI)	members experiencing a	2. Within a BHUC setting, law enforcement is	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		<u>Documentation</u>
<b>T2016 U5</b> : At a	Individuals receiving this	filed or an IVC has been initiated.	Place of Service: Behavioral Health	<u>Manuals</u>
Tier III BHUC	service will be evaluated,	3. This BH-CAI service is comprised of four	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	
		<b>5.</b> 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 Requirements	Authorization Parameters	Source(s)
	This is a service that	Initial Requests:	Length of Stay & Units:	Clinical
Facility-	provides an	<b>1.</b> TAR: Required, submitted within 2 business days of admission.	1. No more than 45 days in a 12-	<u>Coverage</u>
Based Crisis	alternative to	2. Service Order: Required, signed by an MD/ DO, PA, NP, or	month period (EPDST exception	Policy No: 8A-
Service for	hospitalization for an	licensed psychologist.	applies).	2, Facility-
Children	eligible member who	3. Pre-Admission Nurse Screening: Required, conducted by an	2. One unit = 1 hour	Based Crisis
and	presents with	RN or LPN under the supervision of an RN to determine medical		Service for
Adolescents	escalated behavior	appropriateness for this LOC and to rule out acute or severe	Level of Care: If SU applies, ASAM	Children and
	due to a mental	chronic comorbidities that could require complex medical	Level 3.7	<u>Adolescents</u>
Code(s):	health, intellectual or	intervention in a higher LOC		
S9484HA	development	4. Clinical Assessment: Required at the time of admission. A full	Age Group: Children (ages 6-17).	PCP Guidance
	disability or	CCA must be completed prior to DC.	Members 18 to 21 are eligible for FBC	Documents &
	substance use	5. Nursing Assessment: Required within 24 hours of admission	Services for Adults.	<u>Templates</u>
	disorder and requires	<b>6.</b> Psychiatric Evaluation: Required within 24 hours of admission		
	treatment in a 24-	7. Tx plan: Required to direct tx and interventions during the stay.	Place of Service: Licensed crisis	APSM 45-2
	hour residential	Must include the goal(s), objectives, tx interventions and the	settings	<u>Records</u>
	facility. Under the	individual responsible for carrying out the intervention.		<u>Management</u>
	direction of a	8. Care Coordination Referral: If not already linked with a care	Service Specifics, Limitations/	<u>and</u>
	psychiatrist, this	coordinator, a referral should be made for care coordination	Exclusions (not all inclusive):	<u>Documentation</u>
	service provides	within 24 hours of admission.	1. Within 24-hrs of admission, provider	<u>Manuals</u>
	assessment and	9. Submission of applicable records that support the member has	must contact the MCO to determine if	
	short-term	met the medical necessity criteria.	the member is enrolled with another	
	therapeutic		service provider or if the member is	
	interventions	Reauthorization Requests:	receiving care coordination. If the	
	designed to prevent	1. TAR: Required	member is not already linked with a	
	hospitalization by de-	2. Updated Tx Plan: to include the goal(s), objectives, treatment	care coordinator, a referral must be	
	escalating and	interventions and who is responsible for each.	made.	
	stabilizing acute	3. Discharge/ Aftercare Plan: to include: a) the date, time and	2. MCD will not cover Facility-Based	
	responses to crisis	location of first follow up appointment; b) the behavioral health	Crisis Service delivered to a child or	
	situations.	services to be provided; c) living and educational or vocational	adolescent stepping down from an	
		arrangements; d) the members current treatment and care	inpatient level of care.	
		coordination needs; and. e) diagnosis and discharge medications	3. IDD Exclusion Rules apply [see	
		<b>4.</b> Crisis Plan: to includes interventions to prevent readmission	NCGS 122C-261(f), 122C-262(d), and	
		into a crisis setting	122C 263(d)(2)]	
		5. Submission of applicable records that support the member has		
		met the medical necessity criteria.		

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

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

Service &	Brief Service	Auth Submission	Authorization Parameters	Source(s)
Code	Description	Requirements		` ,
	This is an <u>ASAM</u>	Pass-Through Period:	Length of Stay:	Clinical Coverage
Inpatient	Level 4 for	Prior authorization is not required for	1. Initial requests (after the pass-through): Up to 10 units per	Policy No: 8-B,
Behavioral	adolescent and	the first 72 hours of service.	auth.	Inpatient Behavioral
Health	adult members		2. Reauthorization requests: Up to 10 units per auth. Reauth	Health Services
Services:	whose acute	Initial Requests (after pass-	requests must be submitted prior to the end of the current auth. A	
Medically	<u>biomedical,</u>	through):	late submission resulting in unauthorized days requires splitting	July 2012 MCD
Managed	<u>emotional,</u>	1. TAR: prior authorization required	the stay for claims payment purposes.	<b>Bulletin: Authorization</b>
Intensive	<u>behavioral and</u>	within the first 72 hours of service	<b>3.</b> Retrospective auths due to late submissions is not permitted.	Requests by
Inpatient	<u>cognitive</u>	initiation.		Psychiatric Inpatient
Services	<u>problems are so</u>	2. CCA or DA: Required, an initial	<u>Units</u> : Per diem based on the midnight bed count	Acute Care
(Using DRG)	severe that they	assessment must be completed		<u>Providers</u>
	<u>require primary</u>	within 72 hours of admission and	Age Group: Adolescent and Adult	
Code(s):	<u>medical and</u>	updated prior to discharge to		JCB #J277:
100: Inpatient	nursing care.	determine the next clinically	Place of Service: This service may be provided in a licensed	<u>Authorization</u>
Behavioral	The outcome of	appropriate level of care. See CCP	community hospital or a facility licensed under 10A NCAC 27G	Requests for
Health	this level of care	Section 7.5 for specific requirements.	.6000, unless provided by an IHS or compact operated by a	Services When a
Services	is stabilization of	3. Certificate of Need (CON):	Federally Recognized Tribe as allowed in 25 USC 1621t and	Third-Party Payer is
	acute signs and	Required at admission to a	1647a, or provided by a State or Federally operated facility as	<u>Primary</u>
160: Inpatient	symptoms of	freestanding psych hospital or within	allowed by §122C-22. (a)(3). This substance use disorder service	
Behavioral	substance use,	14 calendar days of an emergency	may be provided in an IMD.	JCB #J265:
Health	and a primary	admission for members under 21.		Clarification of
Services in an	focus of the	4. Service Order: Required, signed	Service Specifics, Limitations/ Exclusions (not all inclusive):	Services in an IMD
IMD	treatment plan	by a physician, LP, PA, or NP. A	1. The case management component of IIH, MST, CST, ACT,	100 "1040 0110 1140
	should be	signed H&P/ Initial Psychiatric Eval	SAIOP, SACOT & CADT can be provided to those admitted to or	JCB #J348: SUD IMD
	coordination of	meets this requirement.	discharged from this service. Support provided should be	<u>Clarification</u>
	care to ensure a	5. Service Plan/ Plan of Care/ Tx	delivered in coordination with the Inpatient facility.	ADOM 45 0 December
	smooth	Plan: Required	2. Discharge planning shall begin upon admission to the service.	APSM 45-2 Records
	transition to the	6. Submission of applicable records	3. This level of care must be capable of initiating or continuing	Management and
	next clinically	that support the member has met the	any MAT that supports the member in their recovery from	<u>Documentation</u>
	appropriate level	medical necessity criteria.	substance use.	<u>Manuals</u>
	of care.	Reauthorization Requests:	<b>4.</b> Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or	CON: Medicaid
		1. TAR: prior authorization required.	members with 3rd-party insurance because MCD is the payer of	Inpatient Psychiatric
		2. Updated Tx Plan/ PCP: Required	last resort. When MCD becomes the primary payer, a primary	Services Under Age
		3. Submission of applicable records	payer auth denial/ exhaustion of benefits letter is submitted with	21
		that support the member has met the	the MCD TAR.	<u> </u>
		medical necessity criteria.	THE WOOD TAIN.	
		medical necessity chiena.		



		5. For ADATCs: For members under the age of 21, admission authorization shall be requested by the facility the next business day following admission if the individual presents directly to the facility, by submitting a completed Non-Covered State Medicaid Plan Services Request Form to the Health Plan. To request reauthorization, 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).	
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Injustient Behavioral Health Services: Medically Managed Intensive Inpatient Moriting Agree to require Initiation.  Code(s): Within The Services of Moriting Agree Intensive Inpatient Moriting Agree Intensive Intensive Intended Intensive Intended Intensive	Service &	Brief Service	Auth Submission	Authorization Parameters	Source(s)
Inpatient Behavioral Behavioral Behavioral Behavioral Health Services withdrawal Services (Using DRG)   Code(s): 100: Inpatient Behavioral Health Services (Using DRG)   Code(s): 100: Inpatient Services	Code	Description	Requirements		. ,
Behavioral Health Services:   Medically services:   Medically services:   Medically services   Medically service					
Health Services: Services:  Medically Managed Intensive Inpatient Services (Using DRC) Intensive Inpatient Services  Management Services (Using DRC) Inpatient Behavioral Health Services Intended Services Intend	-				
Services:  Medically Managed Intensive some to require principal multiple severe to require principal multiple state submission resulting in unauthorized days requires spitting the stay for claims payment purposes.  3. Retrospective auths due to late submissions is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submissions is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submissions is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submissions is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submissions is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submissions is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submission is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submission is not permitted. In the stay for claims payment purposes.  3. Retrospective auths due to late submission is not permitted. In the stay for claims payment purposes.  3. Retrospective au			the first 72 hours of service.	l	Inpatient Behavioral
Medically Managed Managed Intensive Inpatient Services (Using DRG)   Services (Using DRG)	Health	<u>whose withdrawal</u>			Health Services
Managed Intensive Inpatient Withdrawal Management Services (Using DRG)   24-hour observation, monitoring, and within 72 hours of admission and updated prior to discharge to determine the next clinically appropriate level of care. See CCP Services in an IMD   160: Inpatient Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome of this Behavioral Health Services in an IMD   160: Inpatient Setting. The intended outcome		<u>signs and</u>			
Intensive Inpatient Inpatient Inpatient Services (Using DRG) Code(s): 100: Inpatient Behavioral Health or Information of the Inpatient Behavioral Health Services in an IMD  160: Inpatient Service Sin an IMD  160: Inpatient Services in an IMD  170: Inpatient Services in an IMD  180: Inpatient Services Inpatiant Setting. The Intended of Service	Medically				July 2012 MCD
Impatient Withdrawal Management Services (Using DRG)   24-hour observation, monitoring, and withdrawal assessment must be completed within 72 hours of admission and updated prior to discharge to determine the next clinically appropriate level of care. See CCP Services in an IMD   160: Inpatient Behavioral Health Services in an IMD   160: Inpatient Services in an IMD		<u>sufficiently</u>			
Withdrawal Management Services (Using DRG)   2.4-hour observation, monitoring, and withdrawal management services in a Behavioral Health Services (Indicating Services in a Behavioral Health Services in a Behavioral Health Services in a Behavioral Health Services in an IMD   Services in an IMD   Service	Intensive	severe to require	within the first 72 hours of service	<b>3.</b> Retrospective auths due to late submissions is not permitted.	<u>Authorization</u>
Management Services   Code(s):   assessment must be completed within 72 hours of admission and updated prior to discharge to determine the next clinically appropriate level of care.   Section 7.5 for specific requirements.	Inpatient	primary medical	initiation.		Requests by
Services (Using DRG)  Observation, monitoring, and withdrawal behavioral Health Services in an IMD  Services in an IMD  Observation, monitoring, and withdrawal so the member can be safely managed at a less intensive level of care.  Services in an IMD  Observation, monitoring, and withdrawal so the member can be safely managed at a less intensive level of care.  Services (Using DRG)  Within 72 hours of admission and updated prior to discharge to determine the next clinically appropriate level of care. See CCP section 7.5 for specific requirements.  S. Certificate of Need (CON): Required at admission to a freestanding psych hospital or within 14 calendar days of an emergency admission for members under 21.  4. Service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval member can be safely managed at a less intensive level of care.  Reauthorization Requests:  1. TAR: prior authorization required.  Submission of applicable records 1. TAR: prior authorization required.  Submission of applicable records 1. TAR: prior authorization required 3. Submission of applicable records 1. TAR: prior authorization of applicable records 2. Updated Tx Plan/ PCP: Required 3. Submission of applicable records 1. TAR: prior authorization of applicable records 1. TAR: prior authorization of applicable records 1. TAR: prior authorization required.  Service Service: May be provided in a licensed community hospital or a facility and loter upon provided by a Federally operated facility as allowed by \$122C-22.(a)(3). This substance use disorder service may be \$122C-22.(a)(3). This substance use disorder service may be \$122C-22.(a)(3). This substance use disorder service or federally operated broit in IMD.  Service Sprovice in an IMD.  Service Plan/ PCP:	Withdrawal	and nursing care,	2. CCA or DA: Required, an initial	<u>Units</u> : Per diem based on the midnight bed count	Psychiatric Inpatient
Monitoring, and withdrawal management services in a medically Health Behavioral Health Services in an IMD   Services in an IMD   Service sin an IMD   Serv	Management	<u>24-hour</u>	assessment must be completed		Acute Care
withdrawal management services in a Behavioral Health Services in an IMD   Mithdrawal so the member can be safely managed at a less intensive level of care.	Services	observation,	within 72 hours of admission and	Age Group: 18 and older	<u>Providers</u>
Code(s):	(Using DRG)		updated prior to discharge to		
Services in a medically   Health   Services   Inamintored   Services   Serv		<u>withdrawal</u>	determine the next clinically	Place of Service: May be provided in a licensed community	JCB #J277:
Behavioral Health Services    Medically monitored inpatient setting. The intended outcome of this Behavioral Health Services in an IMD   Service in an IMD	Code(s):	<u>management</u>	appropriate level of care. See CCP	hospital or a facility licensed under 10A NCAC 27G .6000 unless	<u>Authorization</u>
Health Services    Manuals	100: Inpatient	services in a	Section 7.5 for specific requirements.	provided by an IHS or compact operated by a Federally	Requests for
Services    Inpatient setting   The intended   160: Inpatient	Behavioral	<u>medically</u>	3. Certificate of Need (CON):	Recognized Tribe as allowed in 25 USC 1621t and 1647a, or	Services When a
The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member than part of the care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  The intended outcome of this level of care is to sufficiently and management component of IIH, MST, CST, ACT, SAIOP, & SACOT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  2. Discharge planning shall begin upon admission to the service.  3. This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use.  4. Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benef	Health	<u>monitored</u>	Required at admission to a	provided by a State or Federally operated facility as allowed by	Third-Party Payer is
outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.    A service Order: Required, signed by a physician, LP, PA, or NP. A member can be safely managed at a less intensive level of care.    A service Order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement.   A service Specifics, Limitations/ Exclusions (not all inclusive):   A service Order: Required, signed by a physician, LP, PA, or NP. A salone, and symptoms of withdrawal so the meets this requirement.   SaloP, & SACOT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.   D ischarge planning shall begin upon admission to the service.   A prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with	Services	inpatient setting.	freestanding psych hospital or within	§122C-22.(a)(3). This substance use disorder service may be	<u>Primary</u>
Behavioral Health Services in an IMD    Service order: Required, signed by a physician, LP, PA, or NP. A signed H&P/ Initial Psychiatric Eval meets this requirement.   Service Plan/ Plan of Care/ Tx Plan: Required at a less intensive level of care.		The intended	14 calendar days of an emergency	provided in an IMD.	
Health Services in an IMD  Service in an IMD  Services in an IMD  Services in an IMD  Services in an IMD  Service in an IMD  Service in an IMD  Service in an IMD  Service in an IMD  Services in an IMD  Services in an IMD  Service in an IMD  Service in an IMD  Service in an IMD  Service	160: Inpatient	outcome of this	admission for members under 21.		JCB #J265:
resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  Services in an IMD  resolve the signs and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  Service Plan/ Plan of Care/ Tx Plan: Required  6. Submission of applicable records that support the member has met the medical necessity criteria.  SAIOP, & SACOT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  2. Discharge planning shall begin upon admission to the service.  3. This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use.  4. Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with	Behavioral	level of care is to	4. Service Order: Required, signed	Service Specifics, Limitations/ Exclusions (not all inclusive):	Clarification of
IMD  and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  Plan: Required  6. Submission of applicable records that support the member has met the medical necessity criteria.  Reauthorization Requests:  1. TAR: prior authorization required.  2. Updated Tx Plan/ PCP: Required 3. Submission of applicable records and symptoms of withdrawal so the member can be safely managed at a less intensive level of care.  Impact discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  Impact discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  Impact discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  Impact discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  Impact discharged from this service. Support provided should be delivered in coordination with the Inpatient facility.  Impact delivered in coordination with the Inp	Health	sufficiently	by a physician, LP, PA, or NP. A	1. The case management component of IIH, MST, CST, ACT,	Services in an IMD
withdrawal so the member can be safely managed at a less intensive level of care.  Service Plan/ Plan of Care/ Tx Plan: Required  6. Submission of applicable records that support the member has met the medical necessity criteria.  Seauthorization Requests:  1. TAR: prior authorization required. 2. Discharge planning shall begin upon admission to the service.  3. This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use.  4. Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with	Services in an	resolve the signs	signed H&P/ Initial Psychiatric Eval	SAIOP, & SACOT can be provided to those admitted to or	
Plan: Required Safely managed at a less intensive level of care.  Plan: Required  6. Submission of applicable records that support the member has met the medical necessity criteria.  Reauthorization Requests: 1. TAR: prior authorization required. 2. Updated Tx Plan/ PCP: Required 3. Submission of applicable records 3. This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use. 4. Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with	IMD	and symptoms of	meets this requirement.	discharged from this service. Support provided should be	JCB #J348: SUD
safely managed at a less intensive level of care.  6. Submission of applicable records that support the member has met the medical necessity criteria.  6. Submission of applicable records that support the member has met the medical necessity criteria.  8. This level of care must be capable of initiating or continuing any MAT that supports the member in their recovery from substance use.  8. Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with		withdrawal so the	5. Service Plan/ Plan of Care/ Tx	delivered in coordination with the Inpatient facility.	IMD Clarification
that support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the member in their recovery from substance use.  The support the member has met the medical necessity criteria.  The support the member has met the member in their recovery from substance use.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member in their recovery from substance use.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member has met the medical necessity criteria.  The support the member in their recovery from substance use.  The support the member in their recovery from substance use.  The support the member in their recovery from substance use.  The support the member in their recovery from substance use.  The support the member in their recovery from substance use.  The support the member in their recovery from substance use.  The support the member in their recovery from substance use.  The support the medical necessity criteria.  The support the		member can be	Plan: Required	2. Discharge planning shall begin upon admission to the service.	
intensive level of care.    Management are care.   Substance use.   Management are care care.		safely managed	<b>6.</b> Submission of applicable records	3. This level of care must be capable of initiating or continuing	APSM 45-2
intensive level of care.    Management are care.   Substance use.   Management are care care.		at a less	that support the member has met the	any MAT that supports the member in their recovery from	Records
care.    A. Prior authorization is not required for MCD BH Services rendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with   Documentation   Manuals		intensive level of			Management and
Reauthorization Requests: 1. TAR: prior authorization required. 2. Updated Tx Plan/ PCP: Required 3. Submission of applicable records  Trendered to Medicare/Medicaid dual eligible members or members with 3rd-party insurance because MCD is the payer of last resort. When MCD becomes the primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with Inpatient Psychia		care.	·	4. Prior authorization is not required for MCD BH Services	Documentation
1. TAR: prior authorization required. 2. Updated Tx Plan/ PCP: Required 3. Submission of applicable records 2. Updated Tx Plan/ PCP: Required payer auth denial/ exhaustion of benefits letter is submitted with Inpatient Psychia			Reauthorization Requests:	· ·	Manuals
2. Updated Tx Plan/ PCP: Required 3. Submission of applicable records payer auth denial/ exhaustion of benefits letter is submitted with CD becomes the primary payer, a primary payer, a primary payer auth denial/ exhaustion of benefits letter is submitted with Inpatient Psychia					
3. Submission of applicable records payer auth denial/ exhaustion of benefits letter is submitted with Inpatient Psychia					CON: Medicaid
					Inpatient Psychiatric
					Services Under Age
medical necessity criteria.			• •		



	authorization shall be reday following admission facility, by submitting a plan Services Request authorization, the ADAT Authorization Request to the admission authorization ADATC on the last coverage.	mbers under the age of 21, admission quested by the facility the next business if the individual presents directly to the completed Non-Covered State Medicaid Form to the Health Plan. To request re-C shall submit a completed Electronic to the Health Plan prior to the expiration of tion. The form shall be submitted by the gred day of the existing authorization (or ay if the last covered day occurs on a

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
	This is an organized	Pass-Through Period:	Length of Stay:	Clinical
Medically	facility-based service	Prior authorization is not required for the first 3	1. Initial requests (after the pass-through): Up to 7	Coverage
Monitored	that is delivered by	days of service.	units per auth, with a minimum of 7 days for an	Policy No: 8A-
Inpatient	medical and nursing		initial ADATC services request.	11, Medically
Withdrawal	professionals who	Initial Requests (after pass-through):	<b>2.</b> Reauthorization requests: Up to 7 units per auth.	<u>Monitored</u>
Management	provide 24-hour	1. TAR: Prior approval required w/in the first 3	Reauth requests must be submitted prior to the	<u>Inpatient</u>
Service	medically directed	calendar days of service	end of the current auth. A late submission resulting	<u>Withdrawal</u>
	observation,	2. Initial abbreviated assessment and physical	in unauthorized days requires splitting the stay for	<u>Management</u>
Code(s):	evaluation,	exam conducted by the physician or physician	claims payment purposes.	<u>Service</u>
H0010	monitoring, and	extender OR CCA: completed within three calendar	<b>3.</b> Retrospective auths due to late submissions is	
	withdrawal	days of the admission	not permitted.	APSM 45-2
	management in a	3. Service Plan: Required		Records
	licensed facility. This	<b>4.</b> Service Order: Required, signed by a physician,	<u>Units</u> : One unit = 1 day	<u>Management</u>
	is for a beneficiary	PA, or NP.		and
	whose withdrawal	5. Discharge Planning: Step-down discharge	Age Group: Adolescents and Adults (aged 18 and	<u>Documentation</u>
	signs and symptoms	ASAM LOC must be determined as part of the	older)	<u>Manuals</u>
	are sufficiently severe	CCA	Lavel of Care, ACAMAL aval 2.7 M/M. The ACAMA	
	to require 24-hour	<b>6.</b> Submission of applicable records that support	Level of Care: ASAM Level 3.7 WM. The ASAM	
	observation, monitoring, and	the member has met the medical necessity criteria.	Score must be supported with detailed clinical documentation on each of the six ASAM	
	treatment in a	Reauthorization Requests:	dimensions.	
	medically monitored	1. TAR: Prior approval required	differisions.	
	inpatient setting. A	2. Clinical Institute Withdrawal Assessment of	Service Specifics, Limitations/ Exclusions (not	
	beneficiary at this	Alcohol Scale, Revised (CIWA-Ar) score(s):	all inclusive):	
	level of care does not	Required	1. Provider shall verify each Medicaid beneficiary's	
	need the full	3. CCA: Required if not previously submitted,	eligibility each time a service is rendered.	
	resources of an acute	completed within three calendar days of the	2. Clinical and administrative supervision is	
	care general hospital	admission	covered as an indirect cost and part of the rate	
	or a medically	4. Updated Service Plan: recently reviewed	3. Service must not be billed on the same day	
	managed intensive	detailing the members' progress with the service.	(except day of admission or discharge) as:	
	inpatient treatment	<b>5.</b> Discharge Planning: Step-down discharge	Residential levels of care; Other withdrawal	
	program.	ASAM LOC must be determined as part of the	management services; Outpatient treatment	
	F. 23. 3	CCA	services; SAIOP; SACOT; ACT; CST; Supported	
		<b>6.</b> Submission of applicable records that support	Employment; Psychiatric Rehabilitation; Peer	
		the member has met the medical necessity criteria.	Support Services; Mobile Crisis Management;	
		distribution of the state of th	Partial Hospitalization; Facility Based Crisis (Adult)	
	<u> </u>	<u> </u>	1 (Mail)	<u> </u>



Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
	Mobile Crisis Management	Pass-Through Period:	Units: 1 unit = 15 minutes	Clinical
Mobile Crisis	(MCM)involves all support,	Prior authorization is not required for the first		Coverage Policy
Management	services and treatments necessary to provide	32 units of crisis services per episode.	Age Group: Children, Adolescents & Adults	No: 8A, Enhanced
Code(s): H2011	integrated crisis response, crisis stabilization	Initial (after pass-through) & Reauthorization Requests:	Place of Service: Community settings	Mental Health
Triage and	interventions, and crisis	1. TAR: prior authorization required within 48	Service Specifics, Limitations/ Exclusions	APSM 45-2
Screening is	prevention activities. This	hours of exhausting unmanaged units.	(not all inclusive):	Records
Telehealth Eligible	service is designed to	Note: Clinical docs are only required if more	1. The crisis management provider must	<u>Management</u>
	rapidly assess crisis	than 8 additional units are requested.	contact the MCO to determine if the member	<u>and</u>
	situations and a member's	2. Service Note(s): Required	is enrolled with a provider that should be	<u>Documentation</u>
	clinical condition, to triage	<b>3.</b> ASAM: If applicable, the ASAM Score	involved with the response. Medicaid shall	<u>Manuals</u>
	the severity of the crisis,	must be supported with detailed clinical	not cover services when the service	
	and to provide immediate,	documentation on each of the six ASAM	unnecessarily duplicates another provider's	PCP Guidance
	focused crisis intervention	dimensions.	authorized service.	Documents &
	services which are	4. Person Centered Plan (PCP) Revision	2. Service shall be used to divert members	<u>Templates</u>
	mobilized based on the type and severity of crisis.	Recommendations: Required for those already receiving services, Mobile Crisis	from inpatient psychiatric and detoxification services.	
		Management (MCM) must recommend	3. Priority should be given to a member with a	
		revisions to existing crisis plan components	history of multiple crisis episodes or who are	
		in PCPs. <b>5.</b> Submission of applicable records that	at substantial risk of future crises.	
		support the member has met the medical	Service Exclusions: May not be provided	
		necessity criteria.	concurrently w/: ACT, 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 Requirements	Authorization Parameters	Source(s)
Professional Treatment Services in Facility-Based Crisis Program Code(s): S9484	Service Description  Service provides an alternative to hospitalization for adults (age 18 or older) who have a mental illness or substance use disorder. This can be provided in a non-hospital setting for members in crisis who need short-term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.		Length of Stay: This is a short-term service that cannot be provided for more than 45 days in a 12-month period.  Units: One unit = 1 hour, up to 24 hours in a 24-hour period.  Age Group: Adults (age 18 or older)  Place of Service: Licensed crisis settings  Service Specifics, Limitations/ Exclusions (not all inclusive): Provider will arrange for linkage to services for further tx or rehab upon discharge from the Facility Based Crisis Service. Discharge planning begins at the time of admission for all MH and SU services. The step-down process should afford the member a less restrictive level of	Clinical Coverage Policy No: 8A, Enhanced Mental Health  APSM 45-2 Records Management and Documentation Manuals  PCP Guidance Documents & Templates
			service without losing the focus of tx or interventions required to facilitate continued progress.	