Clinical Policy: Inpatient Behavioral Health Services

Reference Number: WNC.CP.258 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]
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, this service covers:

- Medically Managed Intensive Inpatient Services- Adolescent
- Medically Managed Intensive Inpatient Services- Adult; **AND**
- Medically Managed Intensive Withdrawal Management Services- Adult

For members with Mental health disorders, this service covers:

- Inpatient Psychiatric Hospitalization- Child and Adolescent; **AND**
- Inpatient Psychiatric Hospitalization- Adult

Definitions:

- **The American Society of Addiction Medicine (ASAM) Criteria**: The American Society of Addiction Medicine; is a treatment criterion for addictive, substance-related, and co-occurring conditions.
- **Clinical Institute Withdrawal Assessment of Alcohol Scale** (CIWAAR): Is a tool utilized to assess an individual's alcohol withdrawal.
- **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 member's needs.'

Policy/Criteria[1]
WellCare of North Carolina® shall cover Inpatient Behavioral Health Services when the member meets the specific criteria below:

I. Entrance Criteria for Inpatient Psychiatric Hospital Treatment Admission for a Member Less Than 21 Years Of Age For admission approval, **ALL** criteria must be met:

A. The member shall meet criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5), or any subsequent editions of this reference material, diagnoses, and at least ONE of the following:

1. Member is presently a danger to self as evidenced by engagement 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. member 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 member who has made an attempt, serious gesture or threat.
    b. member manifests a significant depression, including current contemplation of suicide or suicidal ideation, and there is an absence of supervision or structure to prevent suicide.
    c. member has a history of affective disorder:
        i. with mood which has fluctuated to the manic phase, **OR**
        ii. has destabilized due to stressors or non-compliance with treatment.
    d. member is exhibiting self-injurious (can include cutting on self, burning self) behavior or is threatening same with likelihood of acting on the threat; **OR**
2. Member engages in actively violent, aggressive or disruptive behavior or member exhibits homicidal ideation or other symptoms which indicate the member is a probable danger to others. This usually would be indicated by **ONE** of the following:
    a. member whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgment, 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.
    b. member 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 member's specific DSM-5, or any subsequent editions of this reference material, diagnosis and can be treated only in a hospital setting; **or**
3. Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the member unmanageable and unable to cooperate in treatment. This usually would be indicated by **ONE** of the following:
    a. member has recent onset or aggravated psychotic symptoms (can include, disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous speech, severely impaired judgment) **AND**

b. is resisting treatment **or** is in need of assessment in a safe and therapeutic setting; **OR**

4. 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:
   a. 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.
   b. member has a severe eating disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
5. Need for medication therapy or complex diagnostic evaluation where the client'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:
   a. member whose diagnosis and clinical picture is unclear and who requires 24-hour clinical observation and assessment by a multidisciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.
   b. member is involved in the legal system (can include, in a detention or training school facility) and manifests psychiatric symptoms (can include, psychosis, depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs; **AND**

B. Symptoms are not due solely to intellectual disability; **AND**

C. A provider team shall certify that the member meets each of the certification of need requirements listed at 42 CFR 441. 152.

II. Entrance Criteria for Non-Substance Use Disorders for Medicaid Members Ages 21–64 only

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

A. 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; **AND**

B. Symptoms are not due solely to intellectual disability

III. Continued Stay Criteria For Inpatient Psychiatric Hospital Admission For A Medicaid Member Less Than 21 Years Of Age.–

After an initial admission period of **UP TO 72 hours**, a member shall meet **EACH** of the following conditions:

A. 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. Member is not making progress or regressing, and the treatment plan must be modified to identify more effective interventions; **OR**
   b. Member 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 Member are characterized by at least one of the following:
4. Endangerment of self or others; **OR**
5. Behaviors which are grossly bizarre, disruptive, and provocative (can include, feces smearing, disrobing, pulling out hair);
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; **AND**
   a. The symptoms of the member are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.
   b. The services provided in the facility can reasonably be expected to improve the member's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.

IV. <u>Criterion 5 in an Inpatient Psychiatric Facility – Applies only to DSOHF Facilities:</u>

In the event that not all of the criteria for continued acute state in an inpatient psychiatric facility are met, reimbursement may be provided for Members through the age of 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at a

residential rate established by NC Medicaid if the facility and program services are appropriate for the Member's treatment needs and provided that all of the following conditions are met:

A. The psychiatric facility providing continued stay has made a referral for Care Coordination and after care services to WellCare North Carolina®.

B. WellCare and the psychiatric facility have agreed that the Member 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 Member's attending physician.

C. WellCare North Carolina® shall approve for continued stay based on continued stay criteria for members under age 21.

D. The psychiatric facility providing continued stay at a post-acute level of care shall file claims for Medicaid reimbursement.

V. Continued Stay Criteria for Non-Substance Use Disorders for Medicaid Members Ages 21-64 only

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

1. The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the treatment plan **AND**
2. the Member 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;
3. demonstrating inability to adequately care for own physical needs; **OR**
4. requires treatment which is not available **OR**
5. is unsafe on an outpatient basis.
6. The Member's condition must require psychiatric and nursing interventions on a 24-hour basis.

B. Service Exclusions/Limitations

The non-duplicative components, for example case management, of the following services can be provided to Members 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.

VI. Medically Managed Intensive Inpatient Withdrawal Management Services

A. ASAM Level 4WM A. Service Definition and Required Components:

1. 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 Members whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care, 24-hour observation, monitoring, and withdrawal management services in a medically monitored inpatient setting. The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the Member can be safely managed at a less intensive level of care. This level of care must be capable of initiating or continuing any MAT that supports the Member in their recovery from substance use.

VII. Entrance Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders:–

A. The following criteria are to be utilized for review for psychiatric treatment of a Member 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.

VIII. Continued Stay Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders -

A. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's treatment Plan **OR**

B. The member continues to be at risk for relapse based on history or the tenuous nature of the functional gains **OR**

C. Any **ONE** of the following apply:

1. Member has achieved initial Treatment Plan goals and these services are needed to meet additional goals.

2. Member is making satisfactory progress toward meeting goals.

3. Member is making some progress, but the Treatment Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible or can be achieved.)

4. Member is not making progress or regressing; the treatment plan must be modified to identify more effective interventions.

IX. Medically Managed Intensive Inpatient Services (ASAM Level 4)

A. 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 members whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. The outcome of this level of care is stabilization of acute signs and symptoms of substance use, and a primary focus of the treatment plan should be coordination of care to ensure a smooth transition to the next clinically appropriate level of care. This level of care must be capable of initiating or continuing any MAT that supports the Member in their recovery from substance use.

B. When serving adolescents members 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 Member role induction.

X. Entrance Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders - The following are criteria for preadmission review for psychiatric treatment of adult non-substance use disorders **AND** all other conditions:

A. Members shall meet all the criteria below to be approved for admission:

1. The Member 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 Member shall meet the criteria for ASAM level 4- Medically Managed Intensive Inpatient Services and shall meet the specifications in at least one of Dimensions 1, 2, or 3.

XI. Continued Stay Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders

A. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Member's treatment plan or the Member 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. Member has achieved initial treatment plan goals and these services are needed to meet additional goals,
2. Member is making satisfactory progress toward meeting goals,
3. Member is making some progress, but the treatment plan (specific interventions) needs to be modified so that greater gains, which are consistent with the Member's premorbid level of functioning, are possible or can be achieved, **OR**
4. The Member is not making progress or regressing; the treatment plan must be modified to identify more effective interventions.

XII. WellCare of North Carolina® shall **NOT** cover services in a freestanding psychiatric hospital for members 21 through 64 years of age. Please see **Clinical Coverage Policy** *WNC.CP.259 In Lieu of Services (ILOS)* for additional information.

Note: Services noted in this policy must be delivered by practitioners employed by a mental health or substance use provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G."

Background[1]

- WellCare of North Carolina® shall not require prior approval for Inpatient Behavioral Health Services upon admission through the first 72 hours of service..
- Out-of-State emergency admissions **do not** require prior approval; the provider shall contact WellCare Of North Carolina® within **one** business day of the emergency service or emergency admission.
- For *Substance Use Disorders Continued Stay* criteria, the provider shall conduct utilization reviews for continuation of services as needed to ensure that the level of care requested remains medically necessary.
- 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.

A. Utilization Management and Additional Limitations or Requirements

1. Certificates of Need

a. A Certificate of Need (CON) is required for admission to a freestanding hospital for a Medicaid Member less than 21 years of age or a Member ages 6-18 years old.

b. For Medicaid Members, 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 Members, the provider shall maintain a copy of the CON in the Member's health record.
d. Authorization for Medicaid payment begins with the latest signature date on the completed CON form.

2. Utilization Management

a. 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 Member.
b. Services are based upon a finding of medical necessity, must be directly related to the Member's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the Member's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the PIHP or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.
c. 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 Member's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.
d. To request an initial authorization, the 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.
e. 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 PCP and any authorization or reauthorization forms required by the LME-MCO.

B. Provider Qualifications

1. 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).
2. Substance use disorder services can be provided in an Institute of Mental Disease (IMD.)
3. NC Division of Health Service Regulation Mental Health Licensure and Certification Section Refer to https://info.ncdhhs.gov/dhsr/mhlcs/mhpage.html

C. Provider Accreditation

1. The psychiatric hospital or the inpatient program within a general hospital must be accredited by The Joint Commission on Accreditation of Healthcare Organizations.
2. 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.

D. Additional Requirements

1. Compliance

a. 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.

2. Certification of Need for Services

a. The provider shall certify and recertify a Medicaid Member'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.

3. Plan of Care

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

4. Preadmission Authorization and Continued Stay Reviews

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

5. Documentation Requirements

a. Minimum standard is a shift service note that includes:
   i. Member's first and last name and date of birth on each page of the service record;
   ii. The date of service;
   iii. Covered hours for the shift;
   iv. The purpose of contact with the Member;
   v. A description of the interventions;
   vi. The effectiveness of interventions; and
   vii. 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 Member 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:
   i. A comprehensive nursing assessment, performed at admission;
   ii. Approval of the admission by a physician;
   iii. A comprehensive history and physical examination performed within 12 hours admission, accompanied by appropriate laboratory and toxicology tests;
   iv. An addiction-focused history, obtained as part of the initial assessment and reviewed by a physician during the admission process;
   v. A pertinent social, family, and medical history; and
   vi. Other evaluations or assessments as appropriate.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to t

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	05/21	06/21
Annual Review	01/22	02/22
Annual Review	02/23	02/23
NCHC verbiage removed from NC Guidance Verbiage.	03/23	03/23
Annual Review. References updated. Under Description: Added "service coverage for Substance Use Disorder" and for "Mental Health Disorder," Added Definitions for ASAM Criteria, CIWAAR, MAT. Criteria I. Changed title from "Psychiatric Admission Criteria," to "*Entrance Criteria for Inpatient Psychiatric Hospital Treatment Admission for a Member less than 21 years of age"* I.A. added "and at least one of the following" I.A.1. changed, "engages in self-injurious behavior, has a significant potential, or is acutely manic" to "as evidenced by engagement in self-injurious behavior, a severe potential for self-injurious behavior, or is acutely manic," I.A.4.b) removed 'substance use disorder," Added: I.B. "Symptoms are not due solely to intellectual disability; and" *Added Criteria* II. "Entrance Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21–64	08/23	08/23

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
only" *Criteria* III. changed title from "Psychiatric Continued Stay Criteria" to "Continued Stay Criteria for Inpatient Psychiatric Hospital Admission for a Medicaid Member less than 21 years of age" Changed "After an initial admission period of up to three calendar days, for a continuation of an acute stay in an inpatient psychiatric facility," to "After an initial admission period of up to 72 hours," III.A. changed "current symptoms/behaviors" to "current symptoms or behaviors." *III.A.3. changed "Acute" to "Active" and Added III.A.3.a."…not making progress…" III.A.3.b. "making some progress…And the treatment plan must be modified…"* III.B. Deleted "symptoms are not due solely to intellectual disability." Added Criteria *IV. "*Criterion 5 in an Inpatient Psychiatric Facility" "Applies only to DSOHF Facilities" *Added Criteria V. "Continued Stay Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21-64 only"* Added Criteria VI. Medically Managed Intensive Inpatient Withdrawal Management Services which includes language "This level of care must be capable of initiating or continuing any MAT that supports the Member in their recovery from substance use" *Criteria Updated)VII. Changed title from "Preadmission Review Criteria for Substance Use Disorders." To "Entrance Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders" Added a. "any DSM-5" and b. "Meets ASAM Level 4" and Deleted Criteria I.C.1. and I.C.2. Criteria VIII.* Changed title from "*Continued Stay Criteria for Substance Use Disorders" to "Continued Stay Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders"* changed "Person centered Plan" to "treatment plan" and VII.C.4. Added "Member is not making progress or regressing," Added Criteria IX. *Medically Managed Intensive Inpatient Services (ASAM Level 4). Criteria* X. Changed title from "Criteria for Substance Use Disorders" to "*Entrance Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorder"* – Added Criteria 1.DSM-5 And 2.ASAM Level4. Deleted Criteria 1.a-f. *Criteria Added XI. Continued Stay Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders.* BACKGROUND: Changed "authorization of service withing 48 hours of admission" to "shall not require prior approval for Inpatient Behavioral Health services upon admission through the first 72 hours of service." Background 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." Background Added: A. Utilization Management and Additional Limitations or Requirements," "A.1 Certificates of Need," "A.2. Utilization Management," "B. Provider Qualifications," "C. Provider		

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Accreditation," "D. Additional Requirements" "D.1.Compliance" "D.2. Certificate of Need for Service" "D.3. Plan of Care" "D.4. Preadmission Authorization and Continued Stay Reviews" "D.5. Documentation Requirements		
Annual Review. Under Criteria XII, added "**Note:** Services noted in this policy must be delivered by practitioners employed by a mental health or substance use provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G." Removed "Medicaid and health choice" verbiage from References. Changed 'beneficiary' to 'member.' Removed CPT/HCPCS/ICD-10 tables.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 8B Inpatient Behavioral Health Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published June 1, 2023. Accessed June 5, 2024.

North Carolina Guidance

Eligibility Requirements

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.

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 will 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.

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/

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.

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).

Claims-Related Information
Provider(s) shall comply with the NC Tracks 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:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   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 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.
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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.