

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

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:
2A-3, *Out-of-State Services*

1.0 Description of the Procedure, Product, or Service

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

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
None Apply.

2.2 Special Provisions

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

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

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

Medically necessary services 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.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing*

Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

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

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

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

3.2 the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Inpatient Behavioral Health Services when the beneficiary meets the specific criteria in **Subsections 3.2.2 and 3.2.3.**

3.2.2 Psychiatric Admission Criteria for a Medicaid Beneficiary less than 21 years of age or a Health Choice Beneficiary 6 through 18 years of age

Medicaid criteria for the admission of a beneficiary less than 21 years of age to psychiatric hospitals or psychiatric units of general hospitals as well as criteria for the admission of an NCHC beneficiary age 6 through 18 to psychiatric hospitals or psychiatric units of general hospitals are limited herein. Beneficiaries shall meet all the criteria below to be approved for admission.

- a. The beneficiary shall meet criteria for one or more of the following Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material, diagnoses:
 1. Beneficiary is presently a danger to self (e.g., engages in self-injurious behavior, has a significant potential, or is acutely manic). This usually would be indicated by one of the following:
 - A. Beneficiary has made a suicide attempt or serious gesture (e.g., overdose, hanging, jumping from or placing self in front of moving vehicle, self-inflicted gunshot wound), or is threatening same with likelihood of acting on the threat, and there is an absence of supervision or structure to prevent suicide of the beneficiary who has made an attempt, serious gesture or threat.
 - B. Beneficiary 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. Beneficiary 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. Beneficiary is exhibiting self-injurious (cutting on self, burning self) or is threatening same with likelihood of acting on the threat; or
 2. Beneficiary engages in actively violent, aggressive or disruptive behavior or beneficiary exhibits homicidal ideation or other symptoms which indicate the beneficiary is a probable danger to others. This usually would be indicated by one of the following:
 - A. Beneficiary 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. Beneficiary exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (e.g., assaults with or without weapons, provocations of fights, gross aggressive over-reactivity to minor irritants, harming animals or is threatening same with likelihood of acting on the threat. This behavior should be attributable to the beneficiary's specific DSM-5, or any subsequent editions of this reference material, diagnosis and can be treated only in a hospital setting; or
 3. Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the beneficiary unmanageable and unable to cooperate in treatment. This usually would be indicated by one of the following: Beneficiary has recent onset or aggravated psychotic symptoms (e.g., disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous

speech, severely impaired judgment) and 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 (e.g., 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. Beneficiary has a severe eating disorder or substance use 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. Beneficiary whose diagnosis and clinical picture is unclear and who requires 24-hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.
 - B. Beneficiary is involved in the legal system (e.g., in a detention or training school facility) and manifests psychiatric symptoms (e.g., psychosis, depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs; and
- b. A provider team shall certify that the beneficiary meets each of the certification of need requirements listed at 42 CFR 441. 152.

3.2.3 Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility

After an initial admission period of up to three calendar days, the Medicaid or NCHC beneficiary shall meet the criteria below as outlined in 10A NCAC 25C. 0302 to be eligible for a continued acute stay in an inpatient psychiatric facility:

- a. A Medicaid beneficiary less than 21 years of age in a psychiatric hospital or in a psychiatric unit of a general hospital, and to beneficiaries aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital; and
- b. an NCHC beneficiary 6 through 18 years of age in a psychiatric hospital or in a psychiatric unit of a general hospital.

To qualify for Medicaid or NCHC coverage for a continuation of an acute stay in an inpatient psychiatric facility a beneficiary shall meet each of the conditions:

- a. The beneficiary has one of the following:
 1. A current DSM-5, or any subsequent editions of this reference material, diagnosis; or
 2. A current DSM-5, or any subsequent editions of this reference material, diagnosis and current symptoms/behaviors which are characterized by all of the following:

- A. Symptoms or behaviors are likely to respond positively to acute inpatient treatment; and
 - B. Symptoms or behaviors are not characteristic of patient's baseline functioning; and
 - C. Presenting problems are an acute exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change.
- b. Symptoms are not due solely to intellectual disability.
 - c. The symptoms of the beneficiary are characterized by:
 - 1. At least one of the following:
 - A. Endangerment of self or others; or
 - B. Behaviors which are grossly bizarre, disruptive, and provocative (e.g. feces smearing, disrobing, pulling out hair); or
 - C. Related to repetitive behavior disorders which present at least five times in a 24-hour period; or
 - D. Directly result in an inability to maintain age appropriate roles; and
 - 2. The symptoms of the beneficiary are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.
 - d. The services provided in the facility can reasonably be expected to improve the beneficiary's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician.

3.2.4 Medicaid Additional Criteria Covered

In addition to the specific criteria covered in **Subsection 3.2.1** of this policy, Medicaid shall cover Inpatient Behavioral Health Services as detailed in **Subsections 3.2.5, 3.2.6, and 3.2.7.**

3.2.5 Preadmission Review Criteria for Substance Use Disorders for Medicaid Beneficiaries Ages 21–64

The following are criteria for preadmission review for psychiatric treatment of adult alcohol or other substance use disorder.

- a. Any DSM-5, or any subsequent editions of this reference material, diagnosis of a substance use disorder and one of the following:
 - 1. Need for skilled observation (including instance of coma or stupor) or therapeutic milieu necessitating inpatient treatment
 - 2. Need for detoxification and not manageable by alternative treatment
 - 3. Potential danger to self or others and not manageable by alternative treatment
 - 4. Onset of, or impending, convulsions or delirium tremens or toxic psychosis
 - 5. Presence of significant medical disorder or other disabling psychiatric disorder necessitating inpatient treatment
- b. This is used in combination with American Society of Addiction Medicine (ASAM) criteria when appropriate.

3.2.6 Preadmission Review Criteria for Non-Substance Use Disorders for Medicaid Beneficiaries Ages 21–64 only

The following are criteria for preadmission review for psychiatric treatment of adult non-substance use disorders and all other conditions: Any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following:

- a. Impaired reality testing (e.g., delusions, hallucinations), disordered behavior or other acute disabling symptoms not manageable by alternative treatment
- b. Potential danger to self or others and not manageable by alternative treatment
- c. Concomitant severe medical illness or substance use disorder necessitating inpatient treatment
- d. Severely impaired social, familial, occupational or developmental functioning that cannot be effectively evaluated or treated by alternative treatment
- e. Failure of or inability to benefit from alternative treatment, in the presence of severe disabling psychiatric illness
- f. Need for skilled observation, special diagnostic or therapeutic procedures or therapeutic milieu necessitating inpatient treatment

3.2.7 For Medicaid beneficiaries only: Criterion 5 in an Inpatient Psychiatric Facility

In the event that not all of the criteria for continued acute state in an inpatient psychiatric facility as specified in 10A NCAC 25C. 0302 are met, reimbursement may be provided for beneficiaries through the age of 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at a residential rate established by NC Medicaid if the facility and program services are appropriate for the beneficiary's treatment needs and provided that all of the following conditions are met:

- a. The psychiatric facility providing continued stay has made a referral for Care Coordination and after care services to the Local Management Entity (LME), which serves the beneficiary's county of eligibility.
- b. The LME and the psychiatric facility have agreed that the beneficiary has a history of sudden decompensation or measurable regression, and experiences weakness in his or her environmental support system which is likely to trigger a decompensation or regression. This history must be documented by the beneficiary's attending physician.
- c. NC Medicaid utilization review contractor shall approve Medicaid for continued stay based on criteria in **Subsection 3.2.4**.
- d. The psychiatric facility providing continued stay at a post-acute level of care shall file claims for Medicaid reimbursement.

3.2.8 NCHC Additional Criteria Covered

None Apply.

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

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

4.1 General Criteria Not Covered

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

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

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

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for Inpatient Behavioral Health Services. The provider shall obtain prior approval before rendering Inpatient Behavioral Health Services. Hospitals must contact NC Medicaid's utilization review contractor for authorization of services within 48 working hours of admission.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) utilization review contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Medicaid Beneficiaries

Medicaid requires prior authorization for Inpatient Behavioral Health Services for a Medicaid beneficiary aged 0 to 64 years.

5.2.3 NCHC Beneficiaries

None apply.

5.2.4 Medicare/Medicaid Dually Eligible Beneficiaries

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

5.2.5 Out-of-State Emergency Admissions

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

5.3 Additional Limitations or Requirements

5.3.1 Certificates of Need

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

5.3.2 Pending Medicaid Eligibility

- a. A hospital that admits a patient who is not Medicaid eligible on or before admission or is pending eligibility, but who applies for Medicaid during a psychiatric hospitalization, must send the patient's entire health record to the NC Medicaid utilization review contractor for psychiatric review within 30 calendar days of discharge.

- b. If an individual applies for Medicaid after hospital discharge, the individual's complete health record must be sent to the NC Medicaid utilization review contractor within four months of the individual's Medicaid application date.
- c. Hospitals must obtain a Medicaid Identification Number (MID) for the beneficiary and send the MID, along with the health record, to the NC Medicaid utilization review contractor. If eligibility reflects the Medicaid or NCHC application occurred on or before admission rather than during the stay as reported, the hospital stay is not reimbursed.

Retroactive eligibility does not apply to the NCHC Program. An individual is eligible for NCHC on the first day of the month in which the required eligibility conditions are met.

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

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

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

6.1 Provider Qualifications

The provider shall be licensed by the NC Division of Health Service Regulation.

6.2 Provider Accreditation

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

7.0 Additional Requirements

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

7.1 Compliance

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

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Certification of Need for Services

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

7.3 Plan of Care

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

7.4 Preadmission Authorization and Continued Stay Reviews

- a. The NC Medicaid utilization review contractor conducts preadmission authorization and continued stay (concurrent) reviews.
- b. The provider shall prepare a written utilization review plan for each Medicaid or NCHC beneficiary in accordance with 42 CFR 456 Subpart D.

7.5 Documentation Requirements

The provider shall document a shift note for every eight hours of service provided. The note includes each of the following:

- a. beneficiary's first and last name and date of birth on each page of the service record;
- b. the date of service;
- c. the purpose of contact with the beneficiary;
- d. a description of the interventions;
- e. the effectiveness of interventions; and
- f. the signature and credentials of the staff providing the service.

Refer to **Attachment B** for service specific requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: April 1, 2001

Revision Information:

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

Date	Section Revised	Change
12/15/2019	Attachment A	Added: "Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis."
12/15/2019	Attachment A	Added: "Note: North Carolina Medicaid and North Carolina Health Choice will not reimburse for conversion therapy."
12/15/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/15/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines."

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Providers shall bill applicable revenue codes.

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

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

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

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

C. Code(s)

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

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

Unlisted Procedure or Service

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Medical, psychiatric, and substance abuse therapeutic interventions are reimbursed at a per diem rate based on occupancy on the inpatient unit during midnight bed count.

F. Place of Service

Inpatient Behavioral Health services are covered in a hospital as defined in G.S. 131E-176(13).

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

Physician and other professional time not included in the daily rate are billed separately.

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

Attachment B: Inpatient Hospital Substance Abuse Treatment

Billable Service (Using DRG)

Level IV Medically-Managed Intensive Inpatient Services

ASAM Criteria

Example: ATC, general hospital

A. Service Definition and Required Components

Medically-Managed Intensive Inpatient Service is an organized service delivered in an acute care inpatient setting by medical and nursing professionals that provides for 24-hour medically directed evaluation, withdrawal management, and intensive inpatient treatment. It is appropriate for patients whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care.

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

B. Provider Requirements

Medically Managed Intensive Inpatient Services must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.

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

C. Staffing Requirements

Medically Managed Intensive Inpatient Services are staffed by physicians and psychiatrists who are available 24 hours a day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration on an ongoing basis. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders.

Persons who meet the requirements specified for Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialty (LCAS), and Certified Substance Abuse Counselor (CSAC) under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Services. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or LCAS who is available by phone 24 hours a day. The planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Services may also be provided by staff who meet the requirements specified for Qualified Professional (QP) or Associate Professional (AP) status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a LCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Managed Intensive Inpatient Services, under the supervision of a LCAS or CCS.

D. Service Type or Setting

Services provided in a licensed 24-hour inpatient setting. This service may be provided in a licensed community hospital or a facility licensed under 10A NCAC 27G.6000.

E. Utilization Management

Authorization by the NC Medicaid utilization review contractor is required. For Medicaid, initial authorization is limited to seven calendar days.

EPSDT does not apply to NCHC beneficiaries.

F. Entrance Criteria

The following criteria are to be utilized for preadmission review for psychiatric treatment of adult substance use disorders:

1. Any DSM-5, or any subsequent editions of this reference material, diagnosis of substance use or dependence and one of the following:
 - a. Need for skilled observation or therapeutic milieu necessitating inpatient treatment (e.g., inability to maintain abstinence despite attempts at lower levels of care, or unstable outpatient milieu such as family member with active substance use disorder)
 - b. Need for medical detoxification and not manageable by alternative treatment
 - c. Potential danger to self or others and not manageable by alternative treatment
 - d. Onset of, or risk for, seizures, delirium tremens or psychosis
 - e. Presence of significant medical disorder or other disabling psychiatric disorder necessitating inpatient treatment

This is used in combination with ASAM criteria when appropriate. (ASAM Criteria Level 4)

G. Continued Stay Criteria

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

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

The provider shall conduct utilization review every 7 calendar days and document it in the Person-Centered Plan and the service record.

H. Discharge Criteria

The patient continues in Medically Managed Intensive Inpatient Service until withdrawal signs and symptoms are sufficiently resolved that he or she meets medical necessity for and can be managed at a less intensive level of care.

I. Expected Outcomes

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

J. Documentation Requirements

Minimum standard is a shift service note for every 8 hours of services provided that includes the beneficiary's full name, birth date, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature and credentials of the staff providing the service. In addition, detoxification rating scale tables and flow sheets (including tabulation of vital signs) are used as needed. The provider shall discuss the discharge plan with the beneficiary and document the plan in the health record

K. Service Exclusions or Limitations

Mental Health / Substance Abuse Targeted Case Management (MH/SA TCM) and the case management components of Intensive In-Home Services, Multisystemic Therapy, Community Support Team, Assertive Community Treatment Team, Substance Abuse Intensive Outpatient, and Substance Abuse Comprehensive Outpatient may be delivered in coordination with the Inpatient SA Hospital provider and be documented in the Person-Centered Plan. Discharge planning shall begin upon admission to this service.

Services are not covered when the medical necessity criteria for admission or continued stay or the policies listed below are not followed:

1. For Medicaid, prior authorization is required for beneficiaries aged 0 through 64 when receiving behavioral health services. Hospitals must contact the NC Medicaid utilization review contractor for authorization within 48 working hours of an emergency admission.
2. For NCHC, Prior authorization is required for beneficiaries when receiving behavioral health services. Hospitals must contact the NC Medicaid utilization review contractor for authorization within 48 working hours of an emergency admission.
3. For Medicaid, prior authorization is not required for Medicare behavioral health services rendered to Medicare and Medicaid dually eligible beneficiaries.
4. For Medicaid, services are not payable for beneficiaries over the age of 21 or under the age of 65 in a free-standing psychiatric hospital.
5. For Medicaid, a hospital that admits a patient who is not Medicaid eligible on or before admission or is pending eligibility, but who applies for Medicaid during a psychiatric hospitalization, must send the patient's entire medical record to the NC Medicaid utilization review contractor for psychiatric review within 30 days of discharge.
6. For Medicaid, if a patient applies for Medicaid after hospital discharge, the patient's complete medical record shall be sent to the NC Medicaid utilization review contractor within four (4) months of the patient's Medicaid application date.
7. For Medicaid, Hospitals must obtain a MID number for the beneficiary and send the MID number, along with the medical record, to the NC Medicaid utilization review contractor. If eligibility reflects that the Medicaid application occurred on or before admission rather than during the stay as reported, the hospital stay is not reimbursed.
8. For Medicaid, a CON is required for admission to a free-standing hospital for beneficiaries under the age of 21.
9. For NCHC, a CON is required for admission to a free-standing hospital for beneficiaries.
10. The provider shall complete the CON before the date of admission or for emergencies within 14 calendar days of admission. The NC Medicaid utilization review contractor reviews the CONs that are submitted by hospitals to ensure that signatures of the interdisciplinary teams are complete and timely.
11. The provider shall maintain a copy of the CON in the beneficiary's health record.

Attachment C: Inpatient Hospital Psychiatric Treatment (MH)

Billable Service

A. Service Definition and Required Components

Inpatient Hospital Psychiatric Service is an organized service that provides intensive evaluation and treatment delivered in an acute care inpatient setting by medical and nursing professionals under the supervision of a psychiatrist. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric problems.

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

B. Provider Requirements

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

C. Staffing Requirements

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

D. Service Type or Setting

The service is provided in a licensed 24-hour inpatient setting. This service may be provided at a psychiatric hospital or on an inpatient psychiatric unit within a licensed hospital licensed as inpatient psychiatric hospital beds or in State operated facilities. A psychiatric hospital or an inpatient program in a hospital **shall be accredited in accordance with 42 CFR 441.151(a)(2).**"

E. Program Requirements

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

Educational services are not billable to Medicaid or NCHC but must be provided according to state and federal educational requirements.

F. Utilization Management

Authorization by the statewide vendor is required. For Medicaid, this service must be included in the crisis component of a beneficiary's Person-Centered Plan. For Medicaid and NCHC, initial authorization is limited to three (3) days with continued stay reviewed.

G. Certification of Need Process

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

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

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

Retroactive eligibility does not apply to the NCHC program. An individual is eligible for NCHC on the first day of the month in which the required eligibility conditions are met.

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

H. Entrance Criteria

The medical necessity criteria for admission to a psychiatric hospital or to a psychiatric unit of a general hospital are outlined in Section 3 of this policy.

I. Continued Stay Criteria

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

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the treatment plan and the beneficiary continues to be at risk of harming self or others as evidenced by direct threats or clear and reasonable inference of serious harm to self-violent, unpredictable or uncontrollable behavior which represents potential for serious harm to the person or property of others; demonstrating inability to adequately care for own physical needs; or requires treatment which is not available or is unsafe on an outpatient basis. The beneficiary's condition must require psychiatric and nursing interventions on a 24-hour basis.

For Medicaid and NCHC, criteria for continued acute stay in an inpatient psychiatric facility are outlined in Section 3 of this policy. For Medicaid, these criteria apply to beneficiaries under the age of 21 in a psychiatric hospital or in a psychiatric unit of a general hospital and to beneficiaries ages 21-64 receiving treatment in a psychiatric unit of a general hospital.

For Medicaid, utilization review must be conducted every 3 calendar days for non-state operated facilities and is documented in the Person-Centered Plan and the service record.

For NCHC, utilization review must be conducted every 7 calendar days and is documented in the Person-Centered Plan and the service record.

J. Discharge Criteria

The beneficiary no longer meets the continued stay criteria.

K. Expected Outcomes

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

L. Documentation Requirements

Minimum standard is a shift note for every 8 hours of services provided that includes the beneficiary's full name, birth date, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

M. Service Exclusions/Limitations

MH/SA TCM and the case management components of Intensive In-Home Services, Multisystemic Therapy, Community Support Team, Assertive Community Treatment Team, Substance Abuse Intensive Outpatient, and Substance Abuse Comprehensive Outpatient may be delivered in coordination with the Inpatient SA Hospital provider and be documented in the Person-Centered Plan. Discharge planning shall begin upon admission to this service.