

Table of Contents

1.0	Description of the Service.....	1
2.0	Eligible Recipients	1
2.1	General Provisions	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age	1
3.0	When the Service Is Covered.....	2
3.1	General Criteria.....	2
3.2	Psychiatric Admission Criteria/Medicaid Beneficiaries Under Age 21 (10A NCAC 22O.0112)	2
3.3	Preadmission Review Criteria for Substance Abuse/Medicaid Beneficiaries Ages 21–64	4
3.4	Preadmission Review Criteria for Non-Substance Abuse/Medicaid Beneficiaries Ages 21–64	5
3.5	NC Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility (10A NCAC 22O.0113).....	5
4.0	When the Service Is Not Covered.....	6
4.1	General Criteria.....	7
4.2	Non-Covered Services	7
5.0	Requirements for and Limitations on Coverage	7
5.1	Prior Approval	7
5.1.1	Medicare/Medicaid Dually Eligible Recipients.....	7
5.1.2	Out-of-State Emergency Admissions	7
5.2	Recipients with Pending Eligibility	7
5.3	Certificates of Need	8
6.0	Providers Eligible to Bill for the Service	8
6.1	Accreditation.....	8
6.2	Licensure.....	8
7.0	Additional Requirements	8
7.1	Physician Certification.....	8
7.2	Plan of Care	8
7.3	Preadmission Authorization and Continued Stay Reviews.....	8
7.4	Documentation Requirements.....	8
8.0	Policy Implementation/Revision Information.....	9
	Attachment A: Claims-Related Information	10
A.	Claim Type	10
B.	Diagnosis Codes	10
C.	Procedure Code(s).....	10

D. Modifiers.....	10
E. Reimbursement	10
Attachment B: Inpatient Hospital Substance Abuse Treatment.....	11
Service Definition and Required Components.....	11
Provider Requirements.....	11
Staffing Requirements	11
Service Type/Setting.....	12
Utilization Management.....	12
Entrance Criteria	12
Continued Stay Criteria.....	12
Discharge Criteria	13
Expected Outcomes	13
Documentation Requirements.....	13
Service Exclusions/Limitations	13
Attachment C: Inpatient Hospital Psychiatric Treatment (MH)	15
Service Definition and Required Components.....	15
Provider Requirements.....	15
Staffing Requirements	15
Service Type/Setting.....	15
Program Requirements.....	15
Utilization Management.....	16
Certification of Need Process for Persons under Age 21.....	16
Entrance Criteria	16
Continued Stay Criteria.....	17
Discharge Criteria	17
Expected Outcomes	17
Documentation Requirements.....	17
Service Exclusions/Limitations	17

1.0 Description of the 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 recipients with acute psychiatric or substance abuse problems.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396(d)(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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient'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**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers inpatient behavioral health services when they are medically necessary and:

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

3.2 Psychiatric Admission Criteria/Medicaid Beneficiaries Under Age 21 (10A NCAC 22O.0112)

Medicaid criteria for the admission of those persons under age 21 to psychiatric hospitals or psychiatric units of general hospitals is limited herein. To be approved for admission, the patient must meet criteria in Items (1), (2) and (3) of this Rule as follows:

- (1) Client meets criteria for one or more DSM-IV Diagnosis
- (2) At least one of the following criteria:
 - (a) Client 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:

- (i) Client 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 client who has made an attempt, serious gesture or threat.
- (ii) Client manifests a significant depression, including current contemplation of suicide or suicidal ideation, and there is an absence of supervision or structure to prevent suicide.
- (iii) Client has a history of affective disorder:
 - (A) with mood which has fluctuated to the manic phase, or
 - (B) has destabilized due to stressors or non-compliance with treatment.
- (iv) Client is exhibiting self-injurious (cutting on self, burning self) or is threatening same with likelihood of acting on the threat; or
- (b) Client engages in actively violent, aggressive or disruptive behavior or client exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others. This usually would be indicated by one of the following:
 - (i) Client whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgment, severe oppositionalism, 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.
 - (ii) Client 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 client's specific DSM-IV diagnosis and can be treated only in a hospital setting; or
- (c) Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the client unmanageable and unable to cooperate in treatment. This usually would be indicated by one of the following: Client 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
- (d) 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:

- (i) Proposed treatments require close medical observation and monitoring to include, but not limited to, close monitoring for adverse medication effects, capacity for rapid response to adverse effects, and use of medications in clients with concomitant serious medical problems.
- (ii) Client has a severe eating disorder or substance abuse disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
- (e) 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:
 - (i) Client whose diagnosis and clinical picture is unclear and who requires 24 hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.
 - (ii) Client 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
- (3) To meet the federal requirement at 42 CFR 441. 152, all of the following must apply:
 - (a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
 - (b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
 - (c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

3.3 Preadmission Review Criteria for Substance Abuse/Medicaid Beneficiaries Ages 21–64

The following criteria are to be utilized for preadmission review for psychiatric treatment of adult alcohol or other substance dependency or abuse.

- a. Any DSM-IV diagnosis of substance abuse or dependency 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.

3.4 Preadmission Review Criteria for Non-Substance Abuse/Medicaid Beneficiaries Ages 21–64

The following criteria are to be utilized for preadmission review for psychiatric treatment of adult non-substance abuse and all other conditions: Any DSM-IV Axis I or II 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 abuse 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.

3.5 NC Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility (10A NCAC 22O.0113)

The following criteria apply to individuals under the age of 21 in a psychiatric hospital or in a psychiatric unit of a general hospital, and to individuals aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital. These criteria shall be applied after the initial admission period of up to three days. To qualify for Medicaid coverage for a continuation of an acute stay in an inpatient psychiatric facility a patient must meet each of the conditions specified in Item (1) through (4) of this Rule. To qualify for Medicaid coverage for continued post-acute in an inpatient psychiatric facility a patient must meet all of the conditions specified in Item (5) of this Rule.

- (1) The patient has one of the following:
 - (a) A current DSM-IV, Axis I diagnosis; or
 - (b) A current DSM-IV, Axis II diagnosis and current symptoms/behaviors which are characterized by all of the following:
 - (i) Symptoms/behaviors are likely to respond positively to acute inpatient treatment; and
 - (ii) Symptoms/behaviors are not characteristic of patient's baseline functioning; and
 - (iii) Presenting problems are an acute exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change.
- (2) Symptoms are not due solely to mental retardation.

- (3) The symptoms of the patient are characterized by:
 - (a) At least one of the following:
 - (i) Endangerment of self or others; or
 - (ii) Behaviors which are grossly bizarre, disruptive, and provocative (e.g. feces smearing, disrobing, pulling out hair); or
 - (iii) Related to repetitive behavior disorders which present at least five times in a 24-hour period; or
 - (iv) Directly result in an inability to maintain age appropriate roles; and
 - (b) The symptoms of the patient are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.
- (4) The services provided in the facility can reasonably be expected to improve the patient's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- (5) **Criterion 5** In the event that not all of the requirements specified in Items (1) through (4) of this Rule are met, reimbursement may be provided for patients 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 the Division of Medical Assistance if the facility and program services are appropriate for the patient'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 case Management and after care services to the Local Management Entity (LME), which serves the patient's county of eligibility.
 - (b) The LME working collaboratively with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has found that no appropriate services exist or are accessible within a clinically acceptable waiting time to treat the patient in a community setting.
 - (c) The LME and the psychiatric facility have agreed that the patient has a history of sudden decompensation or measurable regression and experiences weakness in his or her environmental support system which are likely to trigger a decompensation or regression. This history must be documented by the patient's attending physician.
 - (d) The Utilization Review Contractor shall approve Medicaid for continued stay based on criteria in Sub-items (a)-(c) of this Item.
 - (e) The psychiatric facility providing continued stay at a post-acute level of care will file claims for Medicaid reimbursement.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this

section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Inpatient behavioral health services are not covered when

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

4.2 Non-Covered Services

Services in a freestanding psychiatric hospital are not covered for recipients over 21 or under 65 years old.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior authorization is required for recipients aged 0 to 64 years when receiving behavioral health services. Hospitals must contact the utilization contractor for authorization of services within 48 working hours of admission.

5.1.1 Medicare/Medicaid Dually Eligible Recipients

Prior authorization is not required for Medicare behavioral health services rendered to Medicare/Medicaid dually eligible recipients.

5.1.2 Out-of-State Emergency Admissions

Out-of-state emergency admissions require prior approval from the utilization contractor.

5.2 Recipients with Pending 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 a patient's entire medical record to the Utilization Review Contractor for psychiatric review within 30 days of discharge.
- b. If a patient applies for Medicaid after hospital discharge, the patient's complete medical record should be sent to the Utilization Review Contractor within four months of the patient's Medicaid application date.
- c. Hospitals must obtain a Medicaid Identification Number (MID) for the recipient and send the MID, along with the medical record, to the Utilization Review Contractor. If eligibility reflects the Medicaid application occurred on or before

admission rather than during the stay as reported, the hospital stay is not reimbursed.

5.3 Certificates of Need

- a. A Certificate of Need (CON) is required for admission to a freestanding hospital for recipients under the age of 21.
- b. The CON must be completed before the date of admission or for emergencies within 14 days of admission. The Utilization Review Contractor reviews the CONs that are submitted by hospitals to ensure signatures of the interdisciplinary teams are complete and timely.
- c. A copy of the CON must be maintained in the recipient's medical record.
- d. Authorization for Medicaid payment begins with the latest signature date on the completed CON form.

6.0 Providers Eligible to Bill for the Service

6.1 Accreditation

The Joint Commission on Accreditation of Healthcare Organizations must accredit a psychiatric hospital or an inpatient program in a general hospital.

6.2 Licensure

Hospital licensure is required from the Division of Health Service Regulation.

7.0 Additional Requirements

7.1 Physician Certification

A physician must certify for each recipient that inpatient services in a hospital are needed. Refer to Code of Federal Regulations (CFR) 42 CFR 456.60 and 42 CFR 456.160.

7.2 Plan of Care

A written individual plan of care must be established for each recipient.

7.3 Preadmission Authorization and Continued Stay Reviews

- a. The Utilization Contractor conducts preadmission authorization and continued stay (concurrent) reviews.
- b. A written utilization review plan is required for each psychiatric hospital providing Medicaid services. Refer to CFR 42 Part 456 Utilization Control Subpart D: Mental Hospitals.

7.4 Documentation Requirements

At a minimum, the provider must document a shift note for every eight hours of service provided that includes:

- a. the recipient's name and birth date on each page of the service record,
- b. the date of service,

- c. the purpose of contact,
- 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
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Section 2.2	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
5/1/07	Sections 2 through 4	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
5/1/07	Attachment A	Added the UB-04 as an accepted claims form.
8/1/07	Section 6.2	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Providers bill for services using the UB-92 or UB-04 claim form.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Reimbursement

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. Physician and other professional time not included in the daily rate are billed separately. Providers must bill usual and customary charges.

Attachment B: Inpatient Hospital Substance Abuse Treatment

Medicaid Billable Service (Using DRG)

Level IV Medically-Managed Intensive Inpatient Services

NC Modified ASAM Patient Placement Criteria

Example: ATC, general hospital

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.

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 DMH 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. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

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 hourly basis. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, CCAS, and 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 CCAS who is 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 provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS 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 CCAS or CCS.

Service Type/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

Utilization Management

Authorization by the statewide vendor is required. Initial authorization is limited to seven days. If it is a Medicaid covered service, utilization management will be done by the state vendor or the LME (only after the LME is deemed ready by DHHS). If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

1. Psychiatric admission criteria/Medicaid beneficiaries under age 21 as specified in 10A NCAC 22O.0112 shall be applicable
2. Preadmission review criteria for substance abuse/Medicaid beneficiaries ages 21 through 64.

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

1. Any DSM-IV diagnosis of substance abuse 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
2. This is used in combination with American Society of Addiction Medicine (ASAM) criteria when appropriate. (Level of Care Criteria Level IV NC Modified A/ASAM.)

Continued Stay Criteria

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

AND

Utilization review must be conducted every 7 days and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

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

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.

Documentation Requirements

Minimum standard is a shift service note for every 8 hours of services provided that includes the recipient's 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. A documented discharge plan should be discussed with the client and included in the medical record

Service Exclusions/Limitations

This service cannot be billed on the same day as any other MH/SA service except for the case management component of Community Support for discharge planning purposes only. Community Support-Case management services must be delivered in coordination with the Inpatient SA Hospital provider and be documented in the PCP. Discharge planning should begin upon admission to this service.

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

1. Prior authorization is required for recipients aged 0 through 64 when receiving behavioral health services. Hospitals must contact the utilization contractor for authorization within 48 working hours of an emergency admission.
2. Prior authorization is not required for Medicare behavioral health services rendered to Medicare/Medicaid dually eligible recipients.
3. Services are not payable for recipients over the age of 21 or under the age of 65 in a free-standing psychiatric hospital.
4. Out-of-state emergency admissions require prior approval from the utilization review contractor.
5. 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 utilization review contractor for psychiatric review within 30 days of discharge.
6. If a patient applies for Medicaid after hospital discharge, the patient's complete medical record should be sent to the utilization review contractor within four (4) months of the patient's Medicaid application date.
7. Hospitals must obtain a Medicaid identification (MID) number for the recipient and send the MID number, along with the medical record, to the 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. A Certificate of Need (CON) is required for admission to a free-standing hospital for recipients under the age of 21.

9. The CON must be completed before the date of admission or for emergencies within 14 days of admission. The utilization review contractor reviews the CONs that are submitted by hospitals to ensure that signatures of the interdisciplinary teams are complete and timely.
10. A copy of the CON must be maintained in the recipient's medical record.

Attachment C: Inpatient Hospital Psychiatric Treatment (MH) Medicaid Billable Service

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 individuals 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 their scope of practice prior to or on the day that the services are to be provided.

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. Per 42 CFR Chapter IV 441.151, a psychiatric hospital or an inpatient program in a hospital must be accredited by JCAHO.

Staffing Requirements

Inpatient Hospital Psychiatric Service 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.

Service Type/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. Per 42 CFR Chapter IV 441.151, a psychiatric hospital or inpatient program must be accredited by JCAHO.

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 abuse disorders and milieu treatment; medical care and treatment as needed; supportive services including room and board. A determination of the appropriate services is made by the care providers under the direction of the attending physician. These services are reimbursed at a per diem rate based on occupancy on the inpatient unit during the midnight bed count. Physician and other professional time not included in the daily rate is billed separately. Educational services are not billable to Medicaid, but must be provided according to state and federal educational requirements.

Utilization Management

Authorization by the statewide vendor is required. This service must be included in the crisis component of an individual's Person-Centered Plan. Initial authorization is limited to three (3) days with continued stay reviewed for non-state operated facilities.

If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Certification of Need Process for Persons under Age 21

A certification of need (CON) process is necessary for persons under the age of 21. It 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 individual's situation. For an individual who applies for Medicaid while in the facility/program, the certification (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.

The CON must certify that:

1. Ambulatory care resources available within the community are insufficient to meet the treatment needs of the recipient; and
2. The individual's condition is such that it requires services on an inpatient basis under the direction of a board-eligible or certified child and adolescent psychiatrist or general psychiatrist with experience in treating children and adolescents; and
3. The services can reasonably be expected to improve the recipient's presenting condition or prevent further regression so that the services will no longer be needed.

Entrance Criteria

The medical necessity criteria for admission to a psychiatric hospital or to a psychiatric unit of a general hospital are outlined in 10 NCAC 26B.0112. In general, these criteria require that:

- A. There is a DSM-IV diagnosis of a psychiatric condition

AND

- B. The individual is experiencing at least one of the following:

1. Making direct threats or there is a clear and reasonable inference of serious harm to self where suicidal precautions or observation on a 24-hour basis or intermittent restraints/seclusion are required
2. Actively violent, unpredictable, aggressive, disruptive or uncontrollable behavior which represents potential for serious harm to person or property of others or there is evidence for a clear and reasonable inference of serious harm to others which requires intensive psychiatric nursing interventions on a 24-hour basis
3. Acute onset of psychosis or severe thought disorder or clinical deterioration in condition due to chronic psychosis rendering the individual unable to adequately care for his/her own physical needs, representing potential for serious harm to self, requiring intensive psychiatric and nursing interventions on a 24-hour basis.
4. Presence of medication needs, or a medical process or condition which is life-threatening which requires an acute care setting for treatment
5. Requires complex diagnostic assessment or treatment which is not available or is unsafe on an outpatient basis

AND

- C. As a prerequisite for inpatient hospitalization, all of the following apply:
1. Outpatient services in the community do not meet the treatment needs of the individual.
 2. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician.
 3. The services can reasonably be expected to improve the individual's condition or prevent further regression or that services will no longer be needed.

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 consumer 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 inpatient basis. The individual's condition must require psychiatric and nursing interventions on a 24 hour basis.

NC Medicaid criteria for continued acute stay in an inpatient psychiatric facility are outlined in 10 NCAC 26B.0113. These criteria apply to recipients under the age of 21 in a psychiatric hospital or in a psychiatric unit of a general hospital and to individuals ages 21-64 receiving treatment in a psychiatric unit of a general hospital.

Utilization review must be conducted every 3 days for non-state operated facilities and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

The consumer no longer meets the continued stay criteria.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

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

Documentation Requirements

Minimum standard is a shift note for every 8 hours of services provided that includes the recipient's 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.

Service Exclusions/Limitations

This service cannot be billed on the same day as any other MH/SA service except for discharge planning purposes when transitioning to Community Support, Community Support Team, ACTT, Intensive In-Home Services or Multisystemic Therapy except for the case management component of these services, which must be delivered in coordination with the Inpatient Hospital Psychiatric Treatment provider and can be provided prior to discharge from the Inpatient Hospital Psychiatric Treatment service. Discharge Planning should begin upon admission to this service.