Optum

Optum Behavioral Health Solutions
Medicaid State-Specific
Supplemental Clinical Criteria

North Carolina Medicaid Supplemental Clinical Criteria

Policy Number: BH803NC102023
Effective Date: October 17, 2023

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Crisis Management/Mobile Crisis Management

Mobile Crisis Management: Involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are always available, 24-hours-a-day, 7-days-a-week, 365-days-a-year. Crisis response provides an immediate evaluation, triage and access to acute mental health, intellectual/developmental disabilities, or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports or services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

Mobile Crisis Management also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services must be specified in a beneficiary's Crisis Plan, which is a component of all PCPs

Admission Criteria

- the beneficiary or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH;
- AND
- the beneficiary or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis. OR
- the beneficiary or family members evidence impairment of judgment, impulse control, cognitive or perceptual disabilities; OR
- the beneficiary is intoxicated or in withdrawal, in need of substance use disorder treatment and unable to access services without immediate assistance. Priority should be given to a beneficiary with a history of multiple crisis episodes or who are at substantial risk of future crises.

Continuing Stay Criteria

- The beneficiary is eligible to continue this service if the crisis has not been resolved or his or her crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

Discharge Criteria

- The beneficiary meets the criteria for discharge if any one of the following applies:
  - The Beneficiary's crisis has been stabilized and his or her need for ongoing treatment or supports has been assessed. If the beneficiary has continuing treatment or support needs, a linkage to ongoing treatment or supports has been made.

Service Delivery

- The focus of evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.
- Expected Outcomes: This service includes a broad array of crisis prevention and intervention strategies which assist the beneficiary in managing, stabilizing or minimizing clinical crisis or situations. This service is designed to rapidly assess crisis situations and a beneficiary's clinical condition, to triage the severity of the crisis, and to provide immediate, focused crisis intervention services which are mobilized based on the type and severity of crisis.

Exclusions

- Services that may not be concurrently provided with Mobile Crisis Management include the following:
  - a. Assertive Community Treatment Program;
  - b. Community Support Treatment;
  - c. Intensive In-Home Services;
  - d. Multisystemic Therapy;
  - e. Medical Community Substance Abuse Residential Treatment;
  - f. Non-Medical Community Substance Abuse Residential Treatment;
  - g. Detoxification Services;
  - h. Inpatient Substance Abuse Treatment;
  - i. Inpatient Psychiatric Treatment, and Psychiatric Residential Treatment Facility except for the day of admission.;
  - and
  - j. Mobile Crisis Management services may be provided to an individual who receives inpatient psychiatric services on the same day of service.

Child First

Child First: is an intensive, early childhood, two-generation, home visiting intervention that works with the most vulnerable young children (prenatal through age five years) and their families. The goal is to heal and protect children from trauma and adversity. Child First works to identify children at the earliest possible time to both prevent and decrease emotional and behavioral problems, developmental and learning problems, and abuse and neglect. This innovative, home-based early childhood intervention is embedded in a system of care framework that is designed to decrease the incidence of developmental and learning problems, and abuse and neglect among the vulnerable young children and families. Child First is recognized as an evidence-based model by several national programs and clearinghouses under the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), the California Evidence-based Clearinghouse, the Coalition for Evidence-based Policy, National Registry for Evidence-based Programs and Practices (NREPP), Colorado Blueprints, and the UK-based Early Intervention Foundation.

Philosophy: All young children and their families will have the nurturing, support, and services that they need to promote optimal social-emotional, cognitive and physical health and development.
Child First helps to heal and protect children and families from the devasting effects of trauma and chronic stress by fostering the development of strong, nurturing, caregiver-child relationships, promoting adult capacity and connecting families with needed services.

Admission Criteria

- Children aged 0-3 years who are considered to have:
  - A cognitive or communication developmental delay that impacts or is related to their social well-being
  - Social emotional delay

    OR
- Children age birth thru 5 years of age assessed who meet the DSM 5 criteria (or subsequent editions of this referenced manual) for one or more of the following:
  - Neurodevelopmental Disorders
  - Depressive Disorders
  - Anxiety Disorders
  - Obsessive-Compulsive and related disorders
  - Trauma and Stressor Related Disorders
  - Feeding and Eating Disorders
  - Elimination Disorders
  - Sleep Wake disorders
  - Disruptive, Impulse-Control and Conduct Disorders
  - ***Other Conditions that may be a focus of Clinical Attention Z codes may be used for diagnosis OR
  - Other Conditions (Relational, Child Abuse & Neglect, Exposure to Interpersonal Abuse, Housing and Economic Problems) that are impacting or will be impacting the child's social and emotional well-being without intervention.

Challenges that are likely to impede a child's healthy emotional or cognitive development include but not limited to elevated psycho-social risk (e.g., child abuse and neglect, trauma, domestic violence, maternal depression, substance abuse, homelessness, etc.) or other significant concerns.

Child First Objectives

- The Child First evidence-based intervention is provided in the home by a team of a licensed, Master's level Mental Health/Developmental Clinician and a bachelor's level Family Resource Partner. The intervention includes:
  - Engagement of the family through building a respectful and trusting relationship.
  - Stabilization of the family if they are experiencing immediate, severe challenges, like eviction.
  - Comprehensive assessment of the child's health and development, important relationships, and parental strengths and challenges that directly impact a child's healthy growth and development.
  - Development of a comprehensive, well-coordinated, family-driven plan of care (or treatment plan), in partnership with the family, which is highly individualized and based on family strengths, priorities, culture, and needs.
  - Two-generation, trauma-informed Child-Parent Psychotherapy and parent guidance delivered to enhance the development of a secure, nurturing, protective relationship.
  - Promotion of executive functioning capacity in both the parent and child, through play, interactive activities, and routines.
  - Mental health assessment and consultation within the early care or school environment.
  - Care coordination, including referrals and hands-on assistance, to connect all members of the family with community-based services and supports.

Program Requirements

Services are delivered face to face with child and caregivers primarily in the home. Service can also be held in other locations such as a clinical office, church, private room in a community facility, pediatric clinic, etc. if there are safety or other pressing issues with approval from the Clinical Director/Supervisor. Ideally, every Child First affiliate site has a minimum of four (4) active clinical teams per FT Clinical Supervisor. Clinical teams and Clinical Supervisors must participate in and adhere to weekly individual, team, and group reflective clinical and case supervision schedules. All required assessments measures are to be completed at baseline, 6 month and at discharge of each identified child. At any point while the child is receiving Child First services, the Child First clinical team shall link the beneficiary to an alternative service when clinically indicated and functionally appropriate for the needs of the individual and family.

Utilization Management

This service requires prior authorization and reauthorization at twelve (12) months. Components of the Home-Based Intervention of Child First:

- Comprehensive Assessment of Child and Family Needs
  - This process begins with engagement and trust building. The Child First team members serve as family partners and advocates. They use an ecological approach to assessment in order to understand the child's health and development, the child's important relationships with parents as well as other individuals who care for the child (e.g., early care and education caregivers), child trauma and other stressors (e.g., violence and separation), and the multiple challenges experienced by the parents that interfere with their ability to protect, nurture, and support their child's development. These challenges include external stresses (like poverty, poor health, housing instability, or unemployment) as well as internal psychological history and current functioning (like depression, domestic violence, history of childhood abuse or neglect, or substance abuse). The assessment occurs predominantly in the home, but also in early care and education settings, schools, and in any other environment in which the child spends significant time. The process includes comprehensive history from the parents or caregivers, observation, information from others who interact with the family (verbally or through existing records), health information, and both standardized and informal measures. It informs the formulation or understanding of the difficulties experienced by the child and family and is critical to the development of the Child and Family Plan of Care (or treatment plan).
- Development of Child and Family Plan of Care
  - A family-driven plan of comprehensive, well-coordinated, therapeutic intervention, supports, and services is developed in partnership with the parents or caregivers. This plan reflects the parents' goals, priorities, strengths, culture, and needs. This is an opportunity to build parental capacity to prioritize goals, develop stepwise strategies, and monitor the results, all enhancing parental executive functioning. It not only includes treatment goals and services for the identified

child, but also includes resources for the parents and siblings as well. This plan serves as the Medicaid-compliant treatment plan.

Parent-Child Mental Health Intervention

- Psychotherapeutic intervention and parent guidance start early in the assessment process, especially when children have emotional and behavioral problems or have experienced trauma. A primary goal is to build parents' reflective capacity, to help them understand the meaning, feelings, and motivations which result in difficult child behavior. This process is different from learning a specific strategy to get rid of a "bad" behavior at a particular age. Instead, it equips parents with a method to address behaviors throughout the lives of their children, understanding that behavior is a communication that has meaning.
- The Child First model fully integrates trauma-informed Child-Parent Psychotherapy. The home environment provides an opportunity to respond to identified problems as they arise in their natural setting, is much more convenient, and is without the stigma of going to a mental health facility. The parent-child dyadic, mental health intervention is an opportunity to intervene with two generations simultaneously, both the child and the parent. This is especially important when the parent has experienced trauma and suffers from depression or other mental health problems.
- The intervention operates at multiple levels: Enhancing child safety, understanding normal developmental challenges and facilitating appropriate expectations, understanding unique child sensitivities and processing, understanding the impact of trauma on both child and parents, building child and parent emotional regulation, promoting a joyful and nurturing parent-child relationship, helping to reframe and develop new strategies to respond to the child's behavior, and exploring the relationship between parental feelings and history, and her/his response to the child. The goal is to build a healthy, secure parent-child attachment so that it serves both as a protective buffer to unavoidable stress and directly facilitates emotional, language, and cognitive growth as well as physical health.

Facilitation of Executive Functioning

- The executive functioning capacity of parents and caregivers served by Child First is often severely compromised by the trauma they have experienced from childhood and thereafter and the lack of structure and scaffolding provided by their own parents. They frequently become emotionally dysregulated. They have difficulty with attention, planning, organization, memory, monitoring, and problem solving. The work of CF Clinicians directly improves both child and parental emotional regulation. Care Coordinators use the development and execution of the service plan to help build the parents' executive functioning capacities, so that they can thoughtfully plan, organize, problem solve, and succeed. There is additional focus on interactive, parent-child routines, games, and conversation. These skills enable parents to scaffold the development of executive functioning in their own children, which is essential to their children's educational success.

Consultation in Early Care and Education

- As an integral component of the Child First intervention, the Mental Health Clinician works with the early care and education or school environment to provide consultation to the teacher or caregiver. This is especially critical when there are challenging behaviors within the classroom. The Clinician conducts observations, discusses past and current behavior with the teacher, and helps the teacher understand the meaning of the child's behavior. Together they develop strategies that can meet the child's individual needs and coordinate efforts between the early care setting or school and home.

Care Coordination at the Service Level

- The Family Resource Partner facilitates the coordination of services and the family's access to multiple resources throughout the community, based on the collaborative planning with the parents. S/he provides hands on assistance obtaining information and partnering with community providers, researching program appropriateness and availability, and making and facilitating referrals to provider agencies. S/he will also collaborate with any care coordination activities from the managed care company or other payers. The Family Resource Partner works with the parents to address barriers to service access, renewed problem solving, and revision of the planning for services in consultation with the Mental Health Clinician and the Child First Clinical Director/Supervisor. Eight areas of need are addressed, including:
  - Child: Child development & early care and education, child behavior & emotions, and child health, and
  - Family: Parent support, adult education, family health, adult mental health and substance abuse, and social services and concrete needs.

Expected Outcomes

- By the end of treatment, outcomes include but not limited to:
  - Decrease in child emotional/behavioral challenges
  - Improvement in child's social skills and social competence
  - Improvement in child's language development
  - Strengthening of the parent-child relationship
  - Decrease in identified mental health issues (maternal depression, PTSD, and parenting stress), that negatively impact the child.

Diagnostic Assessment

Diagnostic Assessment: A Diagnostic Assessment is an intensive clinical and functional face-to-face evaluation of a member's mental health, intellectual and developmental disability, or substance use condition. A diagnostic assessment determines whether the beneficiary meets medical necessity and can benefit from: mental health, intellectual disability, developmental disability, or substance use disorder services based on the beneficiary's diagnosis, presenting problems, and treatment and recovery goals. It evaluates the beneficiary's level of readiness and motivation to engage in treatment. This assessment is designed to be delivered in a team approach that results in the issuance of a written report that provides the clinical basis for the development of the beneficiary's treatment or service plan. The written report must be kept in the service record.

- The Diagnostic Assessment must include all the following elements:
  - description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
  - chronological general health, past trauma history and behavioral health history (including both mental health and substance use including tobacco use) of the beneficiary's symptoms, treatment, and treatment response;
  - current medications for medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions.;
  - a review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;
  - evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
  - analysis and interpretation of the assessment information with an appropriate case formulation including determination of American Society of Addiction Medicine (ASAM) level of care when a substance use disorder is present;
  - diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material including mental health, substance use disorders, or intellectual or developmental disabilities, as well as physical health conditions and functional impairment;
  - recommendations for additional assessments, services, supports or treatment based on the results of the diagnostic assessment;
  - the diagnostic assessment must be signed and dated by the licensed professionals completing the assessment; and
  - evidence of an interdisciplinary team service note that documents the team's review and discussion of the assessment.
- The involvement of the team in the delivery of the service is very important and is documented in the team note. Particular emphasis is made on the involvement and participation of all members of the team in the formulation of the diagnoses and treatment recommendations.
- This assessment must be signed and dated by the MD, DO, PA, NP, or licensed psychologist and shall serve as the initial order for services included in the PCP.
- The MD, DO, NP, PA, or psychologist shall have the required experience with the population served in order to provide this service.
- Diagnostic Assessments must be conducted by practitioners employed by a mental health, substance abuse, or intellectual and developmental disability provider meeting 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 credentialed by the LME-MCO. 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 or registered to do business as a corporate entity in the State of North Carolina.

- The Diagnostic Assessment team must include at least two QPs, according to 10A NCAC 27G .0104, both of whom are licensed or certified clinicians. One of the team members must be a QP whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses or addictive disorders. One team member must be an MD, DO, nurse practitioner, physician assistant, or licensed psychologist. For substance use-focused Diagnostic Assessment, the team must include a LCAS. For a member with intellectual and developmental disabilities, the team must include a master's level QP with at least two years of experience with individuals with intellectual and developmental disabilities.

Admission Criteria

- The member is eligible for this service when either of the following criteria are met:
  - there is a known or suspected mental health, substance use disorder, intellectual or developmental disability diagnosis;

  OR
  - initial screening or triage information indicates a need for additional mental health, substance use disorder, intellectual, or developmental disabilities treatment or supports.

Service Delivery

- Expected Outcomes: A Diagnostic Assessment determines whether the member is appropriate for and can benefit from mental health, intellectual disability, developmental disability, or substance abuse services based on the member's diagnosis, presenting problems, and treatment and recovery goals. It also evaluates the member's level of readiness and motivation to engage in treatment. Results from a Diagnostic Assessment include an interpretation of the assessment information, appropriate case formulation, an order for immediate needs and the development of PCP. For beneficiaries with a substance use disorder diagnosis, a Diagnostic Assessment recommends a level of placement using The American Society of Addiction Medicine (ASAM) Criteria.
- A Diagnostic Assessment shall not be billed on the same day as Assertive Community Treatment Team, Intensive In-Home, Multisystemic Therapy or Community Support Team services. If psychological testing or specialized assessments are indicated, they are billed separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.
- Note: For Medicaid beneficiaries under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Facility Based Crisis Services

Facility Based Crisis Services: Facility-Based Crisis Service for children and adolescents is a service that provides an alternative to hospitalization for an eligible member who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility with 16 beds or less. Facility-Based Crisis Service is a direct and indirect, intensive short term, medically supervised service provided in a physically secure setting, that is available 24 hours a day, seven (7) days a week, 365 days a year.

Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.

The Facility-Based Crisis Service includes professionals with expertise in assessing and treating mental health and substance use disorders and intellectual or developmental disabilities. The service must address the age, behavior, and developmental functioning of each member to ensure safety, health and appropriate treatment interventions. The facility must ensure the physical separation of children (refer to Subsection 1.1) from adolescents (refer to Subsection 1.1) by living quarters, common areas, and in treatment. This separation may be accomplished by providing physically separate sleeping areas and using treatment areas and common areas, i.e. dining room, dayroom, and in- and outside recreation areas, if age groups are scheduled at different times. If adults (18 years of age and older) and children and adolescents are receiving services in the same building, the facility must ensure complete physical separation between adults, children/adolescents.

Children are defined as beneficiaries 6 years of age through. Adolescents are defined as beneficiaries 12 years of age through 17.

Admission Criteria

- The member:
  - Has a Mental Health or Substance Use Disorder diagnosis or Intellectual Developmental Disability as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or any subsequent editions of this reference material based on the designation of the facility;
  - Meets American Society of Addiction Medicine (ASAM) Level 3.7 criteria as found in the current edition if the child's primary admitting diagnosis is substance use;
  - Is experiencing an acute crisis requiring short term placement due to serious cognitive, affective, behavioral, adaptive, or self-care functional deficits secondary to the DSM-5 diagnosis (es) which may include but is not limited to:
    - Danger to self or others;
    - Imminent risk of harm to self or others;
    - Psychosis, mania, acute depression, severe anxiety or other active severe behavioral health symptoms impacting safety and level of age appropriate functioning;
    - Medication non-adherence;
    - Intoxication or withdrawal requiring medical supervision, but not hospital detoxification; and
  - The member has no evidence to support that alternative interventions would be equally or more effective, based on current North Carolina community practice standards (such as Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, and American Society of Addiction Medicine); and
  - The member has been determined to have no acute medical/psychiatric condition that requires a more intensive level of medical/psychiatric monitoring and treatment.

Continuing Stay Criteria

- The desired outcome or level of functioning has not been restored, improved, or sustained over the time-frame outlined in the member's service plan or the member continues to be at risk for relapse based on history or the tenuous nature of the functional gains or ANY of the following applies:
  - The member has achieved initial service plan goals and additional goals are indicated;
  - The member is making satisfactory progress toward meeting goals;
  - The member is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains which are consistent with the member's pre-crisis level of functioning are possible or can be achieved;
  - The member is not making progress; the service plan must be modified to identify more effective interventions; or
  - The member is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria

- The member meets the criteria for discharge if one of the following applies:
  - The member has improved with respect to the goals outlined in the service plan and
    - Goals have been achieved; or
    - The child has regained pre-crisis level of functioning; and
    - Discharge to a lower level of care is indicated.
  - The member is
    - Not benefiting from treatment; or
    - Not making progress in treatment; or
    - Is regressing; and
    - All realistic treatment options with this modality have been exhausted.

Service Delivery

- Facility-Based Crisis Service components include:
  - Assessments and evaluation of the condition(s) that has resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs;
  - Intensive treatment, behavior management support and interventions, detoxification protocols as addressed in the member's treatment plan;

- Assessments and treatment service planning that address each of the member's primary presenting diagnoses if the child is dually diagnosed with mental health and substance abuse disorders or mental health or substance abuse with a co-occurring intellectual developmental disability, with joint participation of staff with expertise and experience in each area;
- Active engagement of the family, caregiver or legally responsible person, and significant others involved in the child's life, in crisis stabilization, treatment interventions, and discharge planning as evidenced by participation in team meetings, collaboration with staff in developing effective interventions, providing support for and input into discharge and aftercare plans;
- Stabilization of the immediate presenting issues, behaviors or symptoms that have resulted in the need for crisis intervention or detoxification;
- Monitoring of the member's medical condition and response to the treatment protocol to ensure the safety of the member.

- Discharge Planning includes:
  - Arranging for linkage to new or existing community-based services that will provide further assessment, treatment, habilitation or rehabilitation upon discharge from the Facility-Based Crisis service;
  - Coordination of aftercare with other involved providers, including the child's Primary Care Practitioner and any involved specialist for ongoing care of identified medical condition;
  - Contact for re-entry planning purposes with the child's school or local school or Local Educational Authority as indicated;
  - Arranging for linkage to a higher level of care as medically necessary;
  - Identifying, linking to, and collaborating with informal and natural supports in the community; and
  - Developing or revising the crisis plan to assist the member and their supports in preventing and managing future crisis events.

Outpatient

Outpatient Behavioral Health Services are psychiatric and biopsychosocial assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible beneficiaries.

These services are intended to determine a beneficiary's treatment needs, and to provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the beneficiary's functioning in familial, social, educational, or occupational life domains.

Outpatient behavioral health services are available to eligible beneficiaries and often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

Based on collaboration between the practitioner and beneficiary, and others as needed, the beneficiary's needs and preferences determine the treatment goals, frequency and duration of services, as well as measurable and desirable outcomes.

Admission Criteria

- All the following criteria are necessary for admission of a beneficiary to outpatient treatment services:
  - A Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ([DSM-5] or any subsequent editions of this reference material) diagnosis;
  - Note: Statistical Manual of Mental Disorders, Fifth Edition ([DSM-5], or any subsequent editions of this reference material), will be referred to as DSM-5 throughout this policy.
  - The beneficiary presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the DSM-5 diagnosis;
  - If a higher level of care is indicated but unavailable or the individual is refusing the service, outpatient services may be provided until the appropriate level of care is available or to support the individual to participate in that higher level of care;
  - The beneficiary is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions; and

- There is no evidence to support that alternative interventions would be more effective, based on North Carolina community practice standards (e.g., Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Board of Addiction Medicine).

Continuing Stay Criteria

- The criteria for continued service must meet both "a" and "b":
  - a. Any ONE of the following criteria:
    - The desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the beneficiary's treatment plan;
    - The beneficiary continues to be at risk for relapse based on current clinical assessment, and history: or
    - Tenuous nature of the functional gains;
  - b. Any ONE of the following criteria (in addition to "a.")
    - The beneficiary has achieved current treatment plan goals, and additional goals are indicated as evidenced by documented symptoms; or
    - The beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service is expected to be effective in addressing the goals outlined in the treatment plan.

Discharge Criteria

- Any ONE of the following criteria must be met:
  - The beneficiary's level of functioning has improved with respect to the goals outlined in the treatment plan;
  - The beneficiary or legally responsible person no longer wishes to receive these services; or
  - The beneficiary, based on presentation and failure to show improvement, despite modifications in the treatment plan, requires a more appropriate best practice or evidence-based treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Service Delivery

- Outpatient behavioral health service providers, including those providing Psychotherapy for Crisis and psychological testing, shall be trained in, and follow a rehabilitative best practice or evidence-based treatment model consistent with community practice standards. The treatment model must be expected to produce positive outcomes for the population being treated. The treatment model must address the clinical needs of the beneficiary identified in the comprehensive clinical assessment and on any subsequent assessments. Qualified interpreters shall be used, if necessary, to deliver test instructions in the examinee's preferred language.

Peer Support Services

Peer Support Services (PSS) are an evidenced-based mental health model of care that provides community-based recovery services directly to a Medicaid-eligible adult beneficiary diagnosed with a mental health or substance use disorder. PSS provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. PSS services are directly provided by Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS can be provided in combination with other approved mental health or substance use services or as an independent service. Due to the high prevalence of beneficiaries with co-occurring disorders (mental health, substance use or physical health disorders) it is a priority that integrated treatment be available to these beneficiaries.

PSS are based on the belief that beneficiaries diagnosed with serious mental health or substance use disorders can and do recover. The focus of the services is on the person, rather than the identified mental health or substance use disorder and emphasizes the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery. The services promote skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

Peer Support Services (PSS) are provided one-on-one to the beneficiary or in a group setting. Providing one-on-one support builds on the relationship of mutuality between the beneficiary and CPSS; supports the beneficiary in accomplishing self-identified goals; and may further support the beneficiary's engagement in treatment. Peer Support Services provided in a group

setting allow the beneficiary the opportunity to engage in structured services with others that share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources to assist the beneficiary in his or her recovery. PSS are based on the beneficiary's needs and coordinated within the context of the beneficiary's Person-Centered Plan. Structured services provided by PSS include:

- Peer mentoring or coaching (one-on-one) – to encourage, motivate, and support beneficiary moving forward in recovery. Assist beneficiary with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.
- Recovery resource connecting – connecting a beneficiary to professional and nonprofessional services and resources available in the community that can assist a beneficiary in meeting recovery goals.
- Skill Building Recovery groups – structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.
- Building community – assist a beneficiary in enhancing his or her social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented services that provide a sense of acceptance and belonging to the community, promote learning of social skills and the opportunity to practice newly learned skills.

Admission Criteria

- A comprehensive clinical assessment (CCA), that demonstrates medical necessity must be completed by a licensed clinician prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current CCA. Relevant clinical information must be obtained and documented in the beneficiary's Person Centered Plan (PCP).
- Medicaid shall cover Peer Support Services when ALL following criteria are met:
  - The beneficiary has a mental health or substance use diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;
  - Beneficiary with a substance use diagnosis meets the American Society of Addiction Medicine (ASAM) Level 1 criteria;
  - There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards; and
  - The beneficiary has documented identified needs, in at least ONE or more of the following areas (related to diagnosis):
    - 1. Acquisition of skills needed to manage symptoms and utilize community resources;
    - 2. Assistance needed to develop self-advocacy skills to achieve decreased dependency on the mental health system;
    - 3. Assistance and support needed to prepare for a successful work experience;
    - 4. Peer modeling needed to take increased responsibilities for his or her own recovery; or
    - 5. Peer supports needed to develop or maintain daily living skills.

Continuing Stay Criteria

- The beneficiary meets criteria for continued stay if any ONE of the following applies:
  - The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame documented in the beneficiary's PCP;
  - The beneficiary continues to be at risk for relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains; or
  - Continuation of service is supported by documentation of beneficiary's progress toward goals within the beneficiary's PCP.

Discharge and Transition Criteria

- The beneficiary meets the criteria for discharge if any ONE of the following applies:
  - The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
  - The beneficiary has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services;

- The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or
- The beneficiary chooses to withdraw from Peer Support Services or the legally responsible person(s) chooses to withdraw the beneficiary from services.

Service Delivery

- Medicaid shall require prior approval for Peer Support Services beyond the unmanaged unit limitation. Coverage of Peer Support Services is limited to twenty-four (24) unmanaged units once per episode of care per state fiscal year.
- Providers shall seek prior approval if they are uncertain that the beneficiary has reached the unmanaged unit limit for the fiscal year.
- Providers shall seek prior approval if beneficiary is engaged in other behavioral health or substance use services. Providers shall collaborate with beneficiary's existing provider to develop an integrated plan of care.
- Prior authorization is not a guarantee of claim payment.
- Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A service order must be signed by a physician or other licensed clinician per his or her scope of practice, prior to or on the first day service is rendered.
- Documentation Requirements – The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for the staff member who provided the service. The PCP and a documented discharge plan must be discussed with the beneficiary and documented in the service record.
- The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the beneficiary's PCP. Expected outcomes:
  - increased engagement in self-directed recovery process;
  - increased natural and social support networks;
  - increased ability to engage in community activities;
  - increased ability to live independently as possible and use recovery skills to maintain a stable living arrangement;
  - higher levels of empowerment and hopefulness in recovery;
  - improved emotional, behavioral, and physical health;
  - improved quality of life;
  - improved vocational skills;
  - decreased substance use;
  - decreased frequency or intensity of crisis episodes; or
  - decreased use of crisis services or hospitalizations.

Service Limitations

- Medicaid shall not cover the following activities of Peer Support Services:
  - Transportation for the beneficiary or family members;
  - Habilitation activities;
  - Time spent performing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
  - Clinical and administrative supervision of the Peer Support Specialist which is covered as an indirect cost and part of the rate;
  - Covered services that have not been rendered;
  - Childcare services or services provided as a substitute for the parent or other beneficiaries responsible for providing care and supervision;
  - Services provided to teach academic subjects or as a substitute for education personnel;
  - Interventions not identified in the beneficiary's Person-Centered Plan;
  - Services provided without prior authorization;
  - Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the Person-Centered Plan; and
  - Payment for room and board.

- Additional Limitations
  - A beneficiary can receive PSS from only one provider organization during an active authorization period. The beneficiary may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period.
  - Family members or legally responsible person(s) of the beneficiary are not eligible to provide this service to the beneficiary.
  - A beneficiary with a sole diagnosis of Intellectual/Developmental Disabilities is not eligible for PSS funded by Medicaid.
  - Peer Support must not be provided during the same authorization period as Assertive Community Treatment Team (ACTT), as a peer support specialist is a requirement of that team.
  - Peer Support must not be provided during the same authorization period as Community Support Team (CST), as a peer support specialist may be a component of the service and a beneficiary who is in need of CST and peer support will be offered CST providers who have peers on the team.
  - PSS must not be provided during the same time of day when a beneficiary is receiving Substance Abuse Intensive Outpatient Program (SAIOP) or Substance Abuse Comprehensive Outpatient Treatment (SACOT), Partial Hospitalization, Psychosocial Rehabilitation, Respite, or Individual Support services.
  - PSS must not be duplicative of other Medicaid services the beneficiary is receiving.
  - Transportation of a beneficiary is not covered as a component for this policy. Any provision of services provided to a beneficiary during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided. This limitation does not impact a beneficiary's ability to access non-emergency medical transportation (NEMT).

Partial Hospitalization

Partial Hospitalization (PH) is a short-term service for acutely mentally ill children or adults, which provides a broad range of intensive therapeutic approaches which may include: group activities or therapy, individual therapy, recreational therapy, community living skills or training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. A physician shall participate in diagnosis, treatment planning, and admission or discharge decisions. Physician involvement shall be one factor that distinguishes Partial Hospitalization from Day Treatment Services. This is day or night service that shall be provided a minimum of 4 hours per day, 5 days per week, and 12 months a year (exclusive of transportation time), excluding legal or governing body designated holidays. Partial Hospitalization assists the beneficiary in transitioning from one service to another (an inpatient setting to a community-based service) or preventing hospitalization. This service provides a broad array of intensive approaches, which may include group and individual activities.

Therapeutic Relationship and Interventions: Partial Hospitalization is designed to offer in-person therapeutic interventions to provide support and guidance in preventing, overcoming, or managing identified needs on the service plan to aid with improving the beneficiary's level of functioning in all domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.

Structure of Daily Living Partial Hospitalization: offers a variety of structured therapeutic activities including medication monitoring designed to support a beneficiary remaining in the community that are provided under the direction of a physician, although the program does not have to be hospital - based. Other identified providers shall carry out the identified individual or group interventions (under the direction of the physician). This service offers support and structure to assist the individual beneficiary with coping and functioning on a day-to-day basis to prevent hospitalization or to step down into a lower level of care from inpatient setting.

Cognitive and Behavioral Skill Acquisition: Partial Hospitalization includes interventions that address functional deficits associated with affective or cognitive problems or the beneficiary's diagnostic conditions. This may include training in community living, and specific coping skills, and medication management. This assistance allows beneficiaries to develop their strengths and establish peer and community relationships.

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

Admission Criteria

- The beneficiary is eligible for this service when all of the following criteria are met:
  - Beneficiary must have a mental health diagnosis;
  - The beneficiary is experiencing difficulties in at least one of the following areas:
    - Functional impairment, crisis intervention, diversion, aftercare needs, or at risk for placement outside the natural home setting; and
    - The beneficiary's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following apply:
      - being unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalizations, or institutionalization;
      - presenting with intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting;
      - being at risk of exclusion from services, placement or significant community support system as a result of functional behavioral problems associated with diagnosis;
      - requires a structured setting to monitor mental stability and symptomology, and foster successful integration into the community through individualized interventions and activities; or
      - service is a part of an aftercare planning process (time limited or transitioning) and is required to avoid returning to a higher, or more restrictive level of service.

Continuing 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 service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains or ANY of the following applies:
  - beneficiary has achieved initial service plan goals and additional goals are indicated;
  - beneficiary is making satisfactory progress toward meeting goals;
  - beneficiary is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the beneficiary's premorbid level of functioning are possible or can be achieved;
  - beneficiary is not making progress; the service plan must be modified to identify more effective interventions; or
  - beneficiary is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria

- The beneficiary meets the criteria for discharge if any one of the following applies:
  - Beneficiary's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:
    - beneficiary has achieved goals, discharged to a lower level of care is indicated; or
    - beneficiary is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

Service Delivery

- If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, PH must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision shall be based on ANY of the following:
  - past history of regression in the absence of PH is documented in the beneficiary record; or
  - the presence of a DSM-5 (or any subsequent editions of this reference material) diagnosis that would necessitate a disability management approach. In the event, there are epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.
- Documentation Requirements
  - The minimum documentation is a weekly service note that includes the purpose of contact, describes the provider's interventions, and the effectiveness of the interventions.
- Service Order Requirement

- A physician, doctoral level licensed psychologist, psychiatric nurse practitioners, psychiatric clinical nurse specialist within their scope of practice can order this service. The service must be ordered prior to or on the day the service is initiated.
- Partial Hospitalization is provided in a licensed facility that offers a structured, therapeutic program under the direction of a physician that may or may not be hospital based.

Professional Treatment Services in Facility-Based Program

Professional Treatment Services in Facility-Based Crisis Program: This service provides an alternative to hospitalization for adults who have a mental illness or substance use disorder. This is a 24-hour residential facility with 16 beds or less that provides support and crisis services in a community setting. This can be provided in a non-hospital setting for beneficiaries in crisis who need short-term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations. These services include:

- Therapeutic Relationship and Interventions: This service offers therapeutic interventions designed to support a member remaining in the community and alleviate acute or crisis situations that are provided under the direction of a physician, although the program does not have to be hospital based. Interventions are implemented by other staff under the direction of the physician. These supportive interventions assist the member with coping and functioning on a day-to-day basis to prevent hospitalization.
- Structure of Daily Living: This service is an intensified short-term, medically supervised service that is provided in certain 24-hour service sites. The objectives of the service include assessment and evaluation of the condition(s) that have resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs; to implement intensive treatment, behavioral management interventions, or detoxification protocols; to stabilize the immediate problems that have resulted in the need for crisis intervention or detoxification; to ensure the safety of the member by closely monitoring his or her medical condition and response to the treatment protocol; and to arrange for linkage to services that will provide further treatment or rehabilitation upon discharge from the Facility Based Crisis Service.
- Cognitive and Behavioral Skill Acquisition: This service is designed to provide support and treatment in preventing, overcoming, or managing the identified crisis or acute situations on the service plan to assist with improving the member's level of functioning in all documented domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.
- Resiliency or Environmental Intervention: This service assists the member with remaining in the community and receiving treatment interventions at an intensive level without the structure of an inpatient setting. This structured program assesses, monitors, and stabilizes acute symptoms 24-hours-a-day.

Admission Criteria

- The member is experiencing difficulties in at least one of the following areas:
  - functional impairment;
  - crisis intervention, diversion, or after-care needs; or
  - at risk for placement outside of the natural home setting; and
- The member's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following apply:
  - unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, or institutionalization;
  - intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are enough to create functional problems in a community setting; or
  - at risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.
- Services must be ordered by a primary care physician, psychiatrist or a licensed psychologist prior to or on the day the services are initiated.
- The initial authorization should not exceed 8 days.

Continuing Stay Criteria

- The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the member's service plan or the member continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following applies:
  - member has achieved initial service plan goals and additional goals are indicated;
  - member is making satisfactory progress toward meeting goals;
  - member is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible or can be achieved;
  - member is not making progress; the service plan must be modified to identify more effective interventions; or
  - member is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria

- The member meets the criteria for discharge if any one of the following applies:
- Member's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step-down or no longer benefits or could function at this level of care and ANY of the following apply:
  - member has achieved goals, discharge to a lower level of care is indicated; or
  - member is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.
- Note: Any denial, reduction, suspension, or termination of service requires notification to the member or legal guardian about their appeal rights.
- If the member is functioning effectively with this service and discharge would otherwise be indicated, Facility-based crisis service must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision shall be based on ANY of the following:
  - Past history of regression in the absence of facility-based crisis service is documented in the service record; or
  - In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains, the nature of the member's DSM-5 (or any subsequent editions of this reference material) diagnosis necessitates a disability management approach.

Service Delivery

- Service must be ordered by a primary care physician, psychiatrist or a licensed psychologist. All service orders must be made prior to or on the day service is initiated.
- This is a 24-hour service that is offered seven days a week.

Psychological Services Provided by Health Departments and School-Based Health Center

Psychological Services for children and adolescents are goal-directed interventions designed to enable children, adolescents, and their families to cope more effectively with complex problems.

Services may include comprehensive psychosocial assessments and treatment planning, goal directed psychotherapy (individual, group, or family), and referral to other mental health resources as needed.

These services involve the identification of and intervention with children and adolescents who may be at risk for developing more serious emotional or behavioral problems as well as those who are already experiencing these problems. Early identification and intervention help prevent inappropriate and costly referrals. Making these services available in health departments and in school-based health centers contributes to beneficiary choice and enhances the coordination of physical and behavioral health services.

Goals of this service include:

- Preventing the development of serious emotional or behavioral problems in children and adolescents;
- Increasing effective coping and problem-solving skills of children, adolescents, and their parents;
- Facilitating effective communication between children and parents;
- Increasing parental understanding of child and adolescent development and behavior; and

- Strengthening the beneficiary's and family's support system to more effectively meet their needs.

Admission Criteria

- 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 beneficiary's needs;
- The service can be safely furnished, and not equally effective and more conservative or less costly treatment is available statewide; and
- The service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.
- Assessment services must always include the child or adolescent and in many cases should also include the parent or caregiver. Psychotherapy is focused on the needs of the child or adolescent but may include sessions with only the parents or caregivers when such sessions are in the interest of the child or adolescent. Individualized treatment plans must be designed to build upon strengths and overcome identified problems.
- After a comprehensive psychosocial assessment using an age-appropriate tool or format, one of the following actions must occur:
  - The beneficiary's need for mental health intervention cannot be met by the health department or school-based health center mental health provider and an appropriate referral is made to another provider;
  - A treatment plan based on the beneficiary's strengths and needs and involving the beneficiary or family is developed and implemented for those beneficiaries to be followed through the public health system; or
  - If the assessment indicates no need for further psychosocial intervention services, this information is provided to the referral source as appropriate.
- If a beneficiary is seen by a mental health provider in a health department or school-based health center and is referred and seen by a different provider for emergency mental health services on the same day, both providers may be reimbursed.
- A beneficiary may receive psychological services in the health department or school-based health center sponsored by a health department in conjunction with mental health services provided by another agency if services are coordinated and non-duplicative.

Limitations/Exclusions

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

Additional Requirements

- The following must be documented in the beneficiary's medical record:
  - reason for referral (or reason for visit);
  - assessment results from a standard assessment protocol;
  - diagnosis;
  - a treatment plan signed by clinician and beneficiary (parent or guardian for a younger child);
  - each intervention, including the date and duration of the session in minutes;
  - notes related to the treatment plan that describe the purpose of the contact, the nature of the intervention, and the effectiveness or outcome of the intervention (beneficiary's response to the intervention); and
  - signature and credentials of the person providing the service.
- The following must also be documented, as appropriate:
  - consults with other professionals;
  - follow-up plan; and
  - release of information signed by beneficiary (parent or guardian for a younger child).

Research-Based Intensive Behavioral Health Treatment

Research-Based Intensive Behavioral Health Treatment: RB-BHT services are researched-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a member. Research Based-Behavioral

Health Treatments, demonstrates clinical efficacy in treating ASD, prevents or minimizes the adverse effects of ASD and; promotes, to the maximum extent possible, the functioning of a member.

In accordance with 42 CFR 440.130(c), RB-BHT services are covered as medically necessary services based upon the recommendation and referral of a licensed physician or a licensed doctorate- level psychologist for individuals who have been diagnosed with Autism Spectrum Disorder.

Admission Criteria

- The member is under the age of 21 and is diagnosed with Autism Spectrum Disorder utilizing a scientifically validated tool or tools for diagnosis of ASD.
- For members (0-3), at the time if initiating services, a provisional diagnosis of ASD is accepted.
    - A provisional diagnosis of ASD is a diagnosis made by a licensed professional as provisional or rule-out based on significant concern for ASD (e.g., physician screening results, parent report, early intervention documentation of concern, or observation of symptoms) when a comprehensive evaluation has not yet been completed.
    - Provisional diagnosis maybe made by licensed psychologist, physician, or clinicians with a master's degree for whom this service is within their scope of practice (e.g., licensed Psychological Associate, Licensed Clinical Social Worker).

Continuing Stay Criteria

- the desired outcome or level of functioning is not restored, improved, or sustained over the timeframe outlined in the beneficiary's Treatment Plan; or
- the beneficiary continues to be at risk for regression based on current clinical assessment, history, or the tenuous nature of the functional gains, and the beneficiary meets one of the following conditions;
    - has achieved current Treatment Plan goals and additional goals are indicated as evidenced by documented symptoms;
    - is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Treatment Plan;
    - is making some progress, but the specific interventions, frequency, intensity, and location in the Treatment Plan need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible;
    - fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the Treatment. (In this case, the beneficiary must be reassessed to identify any unrecognized co-occurring disorders or medical issues and treatment recommendations should be revised based on the findings). The treatment team shall also explore personnel changes and changes in RB-BHT modality;
    - is functioning effectively with this service and discharge would otherwise be indicated, however titration of this service is expected. The RB-BHT services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is reduced or removed. The decision must be based on either of the following:
        - A. there is documented history of regression in the absence of RB-BHT team services, or attempts to titrate RB-BHT team services downward have resulted in regression; or
        - B. there is a clinically sound expectation that the core and associated deficits of ASD persist and that ongoing treatment interventions are needed to sustain functional gains.

Discharge Criteria

- A beneficiary shall meet at least ONE of the following to be considered for transition or discharge from a treatment program:
    - a. the beneficiary ages out of the service;
    - b. the family, caregiver, or beneficiary desires to discontinue services;
    - c. the beneficiary who has a provisional diagnosis for ASD does not meet the diagnostic criteria for ASD (as measured by appropriate scientifically validated tools);
    - d. the beneficiary and team determine that RB-BHT services are no longer needed based on the attainment of goals as identified in the Treatment Plan, no additional goals are needed, and a different level of care or level of support would adequately address current goals;
    - e. the beneficiary and the treatment team determine that a different RB-BHT provider agency is needed to attain the goals as identified in the Treatment Plan;

- f. the beneficiary and the treatment team determine that a different RB-BHT treatment modality is needed to attain the goals as identified in the Treatment Plan;
- g. the beneficiary moves out of the catchment area and the provider has facilitated the referral to either a new RB-BHT provider or other appropriate service in the new place of primary private residence and has assisted the beneficiary in the transition process;
- h. the beneficiary and, if appropriate, the legally responsible person, chooses to withdraw from services and documented attempts by the program to reengage the beneficiary with the service have not been successful;
- i. the beneficiary is functioning effectively with this service and discharge is indicated. It is not anticipated that regression is likely to occur if the service is removed. The decision must be based on either of the following:
  - the beneficiary does not have a documented history of regression in the absence of RB-BHT team services, or attempts to titrate RB-BHT team services downward have not resulted in regression; or
  - there is a clinically sound expectation that ongoing treatment interventions are needed to sustain functional gains; or
- j. the beneficiary has not demonstrated significant improvement following reassessment and several adjustments to the treatment plan, personnel or modality over at least six months and:
  - alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement;
  - the beneficiary's core and associated deficits have worsened, such that continued treatment is not anticipated to result in sustainable change; or
  - the beneficiary is not appropriate for the service type.

Service Delivery

- Medicaid shall require prior approval for Research-Based Behavioral Health Treatment services. The provider shall obtain prior approval before rendering Research-Based Behavioral Health Treatment services.
- Behavioral / Adaptive / Functional assessment and development of treatment plan:
  - Delivery of RB-BHT services
    - Adapting environments to promote positive behaviors and learning while reducing negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports);
    - Applying reinforcement to change behaviors and promote learning (e.g. Reinforcement, differential reinforcement of alternative behaviors, extinction);
    - Teaching techniques to increase positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting);
    - Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups);
    - Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software); and
    - Training of parents/ guardians/caregivers on interventions consistent with the RB-BHT.
- Observation and Direction Performing Provider's observation and direction of the BCaBA or Technician, which is reimbursed only when:
  - the Performing Provider is in the same location as both the individual and the BCaBA or technician and
  - the observation is for the benefit of the individual. The Performing Provider delivers observation and direction regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. Observation and direction also inform any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the Treatment Plan. Observation and direction must be provided on an ongoing basis throughout the time that RB-BHT services are being provided to an individual.
- In addition to the categories of interventions listed above, covered RB-BHT services are any other intervention supported by credible scientific or clinical evidence, as appropriate for the treatment of Autism Spectrum Disorder.

Behavioral Health Urgent Care

Behavioral Health Urgent Care (BHUC): is a model of walk-in urgent care tailored for behavioral health crises staffed with behavioral health professionals. BHUC operates six days a week with extended operating hours and closely mirrors urgent

care within physical health care. Members can walk-in to BHUC and receive a crisis assessment. The behavioral health professionals can refer members to ongoing services as appropriate and prescribe medications as a bridge approach until the member makes the first provider appointment for children aged 4-20 and adults MH, SUD, and co-occurring Disorders or members experiencing a BH crisis. The BHUC provides a level of treatment between the outpatient therapist and the crisis facility/ED. BHUC includes an integrated model for urgent care including medical screening, vitals and case management services (linkage, referral). It provides a viable alternative to the 24 hours a day, seven days a week crisis facility and ED. The BHUC focuses on brief assessment and treatment in an urgent care setting specifically for behavioral health crises.

Inpatient/Institutions for Mental Disease

Inpatient: 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.

Institutions for Mental Disease (IMD): Admission to institutions for mental disease (IMDs) is available if the member meets the clinical criteria for admission and seeks care for acute psychiatric care or SUD services. The federal government defines IMDs as hospitals, nursing facilities or other institutions of more than 16 beds. IMDs engage primarily in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Members ages 21 to 64 are eligible for admission to an IMD. The IMD must be the appropriate level of care for the beneficiary. IMD for SUD may be covered without day limits however under the In Lieu of Service benefit, IMD may be covered for mental health short-term stays of 15 days or less.

Preadmission Criteria

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

Admission Criteria

- 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:
  - 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:
    - 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.
    - 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.
    - Beneficiary has a history of affective disorder:
      - With mood which has fluctuated to the manic phase, or
      - Has destabilized due to stressors or non-compliance with treatment.
    - Beneficiary is exhibiting self-injurious (cutting on self, burning self) or is threatening same with likelihood of acting on the threat; or

- 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:
  - 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.
  - 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
- 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
- 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:
  - 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.
  - Beneficiary has a severe eating disorder or substance use disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
- A provider team shall certify that the beneficiary meets each of the certification of need requirements listed at 42 CFR 441. 152.

Continuing Stay Criteria

- 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.
- 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 Medicaid beneficiary less than 21years 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
  - 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:
  - The beneficiary has one of the following:
    - A current DSM-5, or any subsequent editions of this reference material, diagnosis; or
    - A current DSM-5, or any subsequent editions of this reference material, diagnosis and current symptoms/behaviors which are characterized by all the following:
      - Symptoms or behaviors are likely to respond positively to acute inpatient treatment; and
      - Symptoms or behaviors are not characteristic of patient's baseline functioning; and
      - Presenting problems are an acute exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change.
  - Symptoms are not due solely to intellectual disability.
  - The symptoms of the beneficiary are characterized by:
    - At least one of the following:
      - Endangerment of self or others; or
      - Behaviors which are grossly bizarre, disruptive, and provocative (e.g. feces smearing, disrobing, pulling out hair); or

        - Related to repetitive behavior disorders which present at least five times in a 24-hour period; or
        - Directly result in an inability to maintain age appropriate roles; and
      - The symptoms of the beneficiary are characterized by a degree of intensity enough to require continual medical/nursing response, management, and monitoring.
    - 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.

Discharge Criteria

- The beneficiary no longer meets the continued stay criteria.
- The beneficiary will attain a level of functioning including stabilization of psychiatric symptoms and establishment of abstinence enough to allow for subsequent substance use disorder or mental health treatment in a less restrictive setting.

Service Delivery

- 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.
- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.
- During admission, the psychiatrist sees the member at least 5 times per week and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

Opioid Treatment Program

The Opioid Treatment Program (OTP) service is an organized, outpatient treatment service for a beneficiary with an opioid use disorder (OUD). The OTP service utilizes methadone, buprenorphine formulations, naltrexone or other drugs approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorders.

This service is delivered by an interdisciplinary team of professionals trained in the treatment of opioid use disorder. The team provides person-centered, recovery-oriented treatment, case management, and health education. A range of cognitive, behavioral, and substance use disorder (SUD) focused therapies are provided to address substance use that could compromise recovery.

Admission Criteria

- Opioid Treatment Program Service is covered for an eligible beneficiary 18 years of age and older who meets the criteria, when medically necessary, and:
    - 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;
    - the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
    - 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.
    - the beneficiary has a current opioid use disorder (OUD) diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference manual; and
    - the beneficiary meets the American Society of Addiction Medicine (ASAM Criteria) Third Edition for OTP (Opioid Treatment Program specific) level of care.

- Due to the nature of this OTP service, a comprehensive clinical assessment (CCA) or diagnostic assessment (DA) is not required prior to admission. An initial abbreviated assessment, physical exam and service plan must be completed by a physician or approved medical provider (nurse practitioner or physician assistant with a midlevel exemption from SAMHSA) to establish medical necessity for this service as a part of the admission process.
- The initial assessment must contain the following documentation in the beneficiary's service record:
  - presenting problem;
  - needs and strengths;
  - a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a beneficiary admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;
  - a pertinent social, family, and medical history; and
  - evaluations or assessments, such as psychiatric, substance use, medical, and vocational, as appropriate to the client's needs
    - The program physician can bill Evaluation and Management (E/M) code separately for the admission evaluation and physical exam.
    - A licensed professional shall complete a CCA or DA within ten (10) calendar days of the admission, to determine an ASAM level of care for discharge planning. Information from the abbreviated assessment can be utilized as part of the current CCA. Relevant diagnostic information must be obtained and contained in the treatment or service plan.
    - The licensed professional may update the initial assessment or a recent CCA or DA from another clinician if a substantially equivalent assessment is available and reflects the current level of functioning. Information from that assessment can be used as part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and contained in the treatment or service plan.

Continuing Stay Criteria

- The beneficiary is eligible to continue this service if there is documentation of the beneficiary's current status based on the six (6) dimensions of the ASAM Criteria for OTP that indicates a need for continued stay. Justification must be provided based on current level of functioning in each of the six (6) dimensions of the ASAM Criteria. Documentation must contain details of the assessment of the six (6) dimensions.
  - In addition to the above, the beneficiary shall meet one of the following:
    - has achieved current Person-Centered Plan (PCP) goals and additional goals are indicated as evidenced by documented symptoms;
    - is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service is effective in addressing the goals outlined in the PCP; OR
    - is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible.
  - If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, this service must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on ANY ONE of the following:
    - A history of regression in the absence of opioid treatment is documented in the beneficiary's service record;
    - A presence of a DSM-5 (or any subsequent editions of this reference material) diagnosis that would necessitate a chronic disease management approach, in the event that there are medically sound expectations that symptoms persist and that ongoing treatment interventions are needed to sustain functional gains; or
    - There is a lack of a medically appropriate step down.

Discharge and Transition Criteria

- The beneficiary meets the criteria for transfer or discharge if the following applies:
  - Documentation of the beneficiary's current status based on the ASAM Criteria six (6) dimensions for OTP that indicates a need for transfer or discharge. Justification must be provided based on current level of functioning in the six (6) dimensions of the ASAM Criteria. Documentation must contain details of the assessment of the six (6) dimensions; and
  - The beneficiary meets one of the following:
    - The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care, including a coordinated transition to Office Based Opioid

Treatment (OBOT), as medically necessary, and there are no medical expectations that symptoms persist without ongoing medication or change in medication;
    - The beneficiary has achieved positive life outcomes that support stable and ongoing recovery, there is low potential for regression, there is no medical expectation that symptoms persist, and ongoing treatment interventions are not needed to sustain functional gains at this level of care, there is a transition plan to step down to a lower level of care, including a coordinated transition to OBOT, as medically necessary, and the beneficiary is no longer in need of the OTP Service; or
    - The beneficiary or legally responsible person requests a discharge from OTP Service or other Medication Assisted Treatment.

Service Delivery

- Medicaid shall not require initial prior approval for the OTP Service.
- A service order must be signed prior to or on the first day service is rendered.
    - Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by a physician, physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for 12 months. Medical necessity must be revisited, and the service must be ordered at least annually, based on the date of the original service order.
- Utilization management of covered services is part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary. All utilization review activity must be documented in the service record and be maintained by the program.

Service Limitations

- Medicaid shall not cover the following:
    - Any services in the OTP Service per diem as separate billable services unless otherwise indicated in this clinical coverage policy;
    - Transportation for the beneficiary or family members;
    - Any habilitation activities;
    - Time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill assistance;
    - Clinical and administrative supervision of OTP Service staff, which is covered as an indirect cost and part of the rate;
    - Covered services that have not been rendered;
    - Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
    - Services provided to teach academic subjects or as a substitute for education personnel;
    - Interventions not identified on the beneficiary's PCP;
    - Services provided without prior authorization by the PIHP;
    - Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's needs and not listed on the PCP; and
    - Payment for room and board.

Ambulatory Detoxification

Ambulatory Detoxification is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. The services are designed to treat the beneficiary's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the beneficiary's transition into ongoing treatment and recovery.

A service order for Ambulatory Detoxification must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Admission Criteria

- The beneficiary is eligible for this service when all the following criteria are met:
  - There is a substance use disorder diagnosis present; and
  - The beneficiary meets ASAM Level I-WM criteria.

Continuing Stay and Discharge Criteria

- The beneficiary continues in Ambulatory Detoxification until ANY of the following criteria are met:
  - Withdrawal signs and symptoms are sufficiently resolved such that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing detoxification monitoring; or
  - The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

- The expected outcome is abstinence and reduction in any psychiatric symptoms (if present).

Substance Abuse Intensive Outpatient Program

Substance Abuse Intensive Outpatient Program (SAIOP) means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent beneficiaries to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a day, at least 3 days a week, with no more than 2 consecutive days between offered services and distinguishes between those beneficiaries needing no more than 19 hours of structured services per week (ASAM Level 2.1). The beneficiary must be in attendance for a minimum of 3 hours a day in order to bill this service. SAIOP services shall include a structured program consisting of, but not limited to, the following services:

- Individual counseling and support;
- Group counseling and support;
- Family counseling, training or support;
- Biochemical assays to identify recent drug use (e.g. urine drug screens);
- Strategies for relapse prevention to include community and social support systems in treatment;
- Life skills;
- Crisis contingency planning;
- Disease Management; and
- Treatment support activities that have been adapted or specifically designed for beneficiaries with physical disabilities; or beneficiaries with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability and substance use disorder.

SAIOP can be designed for homogenous groups of beneficiaries e.g., pregnant women, and women and their children; individuals with co-occurring mental health and substance use disorders; individuals with human immunodeficiency virus (HIV); or individuals with similar cognitive levels of functioning. Group counseling shall be provided each day SAIOP services are offered.

SAIOP includes:

- a. case management to arrange, link or integrate multiple services; and
- b. assessment and reassessment of the beneficiary's need for services.

SAIOP services also:

- a. inform the beneficiary about benefits, community resources, and services;
- b. assist the beneficiary in accessing benefits and services;
- c. arrange for the beneficiary to receive benefits and services; and
- d. monitor the provision of services.

Beneficiaries may be residents of their own home, a substitute home, or a group care setting; however, the SAIOP must be provided in a setting separate from the beneficiary's residence. The program is provided over a period of several weeks or months.

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

Admission Criteria

- The beneficiary is eligible for this service when ALL of the following criteria are met:
  - there is a substance use disorder diagnosis present; and
  - the beneficiary meets ASAM Level 2.1 criteria.

Continuing Stay Criteria

- The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP 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 applies.
  The beneficiary:
  - has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated;
  - is making satisfactory progress toward meeting goals;
  - is making some progress, but the PCP (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;
  - is not making progress; the PCP must be modified to identify more effective interventions; or
  - is regressing; the PCP must be modified to identify more effective interventions.

Discharge Criteria

- The beneficiary meets the criteria for discharge if any one of the following applies:
  - The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply. The beneficiary:
    - has achieved positive life outcomes that support stable and ongoing recovery;
    - is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; or
    - no longer wishes to receive SAIOP services.

Service Delivery

- Expected Outcomes The expected outcome of SAIOP is abstinence.
  - Secondary outcomes include:
    - sustained improvement in health and psychosocial functioning;
    - reduction in any psychiatric symptoms (if present),
    - reduction in public health or safety concerns; and
    - reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors.
- Documentation Requirements The minimum standard is a daily full service note for each day of SAIOP that includes:
  - the beneficiary's name;
  - Medicaid identification number;
  - date of service;
  - purpose of contact;
  - describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions;
  - the signature and credentials of the staff providing the service. A documented discharge plan shall be discussed with the beneficiary and included in the record.

Service Limitations

- SAIOP cannot be billed during the same authorization as SA Comprehensive Outpatient Treatment, all detoxification services levels, Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Substance Abuse Comprehensive Outpatient Treatment

Substance Abuse Comprehensive Outpatient Treatment (SACOT) program means a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery.

- SACOT Program is a service emphasizing:
  - reduction in use of substances or continued abstinence;
  - the negative consequences of substance use;
  - development of social support network and necessary lifestyle changes;
  - educational skills;
  - vocational skills leading to work activity by reducing substance use as a barrier to employment;
  - social and interpersonal skills;
  - improved family functioning;
  - the understanding of addictive disease; and
  - the continued commitment to a recovery and maintenance program.

- These services are provided during day and evening hours to enable beneficiaries to maintain residence in their community, continue to work or go to school, and to be a part of their family life. The following types of services are included in the SACOT Program:
  - individual counseling and support;
  - group counseling and support;
  - family counseling, training or support;
  - biochemical assays to identify recent drug use (e.g., urine drug screens);
  - strategies for relapse prevention to include community and social support systems in treatment;
  - life skills;
  - crisis contingency planning;
  - disease management; and
  - treatment support activities that have been adapted or specifically designed for beneficiaries with physical disabilities; or beneficiaries with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability and substance use disorder.

- SACOT programs can be designed for homogenous groups of beneficiaries, including:
  - beneficiaries being detoxed on an outpatient basis;
  - beneficiaries with chronic relapse issues;
  - pregnant women, and women and their children;
  - beneficiaries with co-occurring mental health and substance use disorders;
  - beneficiaries with HIV; or
  - beneficiaries with similar cognitive levels of functioning.

- SACOT includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the beneficiary's need for services. SACOT services also:
  - inform the beneficiary about benefits, community resources, and services;
  - assist the beneficiary in accessing benefits and services;
  - arrange for the beneficiary to receive benefits and services; and
  - monitor the provision of services.

- Beneficiaries may be residents of their own home, a substitute home, or a group care setting; however, the SACOT Program must be provided in a setting separate from the beneficiary's residence.

- A service order for SACOT must be completed prior to or on the day that the services are to be provided by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice.
- This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day, with availability at least 5 days per week with no more than 2 consecutive days without services available. The beneficiary must be in attendance for a minimum of 4 hours a day in order to this for this service. Group counseling services must be offered each day the program operates. Services must be available during both day and evening hours.
- A SACOT Program may have variable lengths of stay and reduce each beneficiary's frequency of attendance as recovery becomes established and the beneficiary can resume more and more usual life obligations. The program conducts random drug screening and uses the results of these tests as part of a comprehensive assessment of participants' progress toward goals and for Person - Centered Planning.

Admission Criteria

- The beneficiary is eligible for this service when the following criteria are met:
  - there is a substance use disorder diagnosis present;
    AND
  - the beneficiary meets ASAM Level 2.5 criteria.

Continuing Stay Criteria

- The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP 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 applies:
  - beneficiary has achieved initial PCP goals and continued service at this level is needed to meet additional goals;
  - beneficiary is making satisfactory progress toward meeting goal;.
  - beneficiary is making some progress, but the PCP (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;
  - beneficiary is not making progress; the PCP must be modified to identify more effective interventions; or
  - beneficiary is regressing; the PCP must be modified to identify more effective interventions.
    AND
  - Utilization review must be conducted every 30 days and is so documented in the PCP and the service record.

Discharge Criteria

- The beneficiary meets the criteria for discharge if any one of the following applies:
  - Beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:
    - beneficiary has achieved positive life outcomes that support stable and ongoing recovery;
    - beneficiary is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; or
    - beneficiary or family no longer wishes to receive SACOT services.

Service Delivery

- The expected outcome is abstinence.
  - Secondary outcomes include:
    - sustained improvement in health and psychosocial functioning;
    - reduction in any psychiatric symptoms (if present);
    - reduction in public health or safety concerns; and
    - a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.
- For beneficiaries with co-occurring mental health and substance use disorders, improved functioning is the expected outcome.

- Documentation Requirements
  - The minimum standard is a daily full service note for each day of SACOT that includes:
    - a. beneficiary's name;

    - b. Medicaid identification number;
    - c. date of service;
    - d. purpose of contact;
    - e. description of the provider's interventions, the time spent performing the intervention, the
    - effectiveness of interventions; and
    - f. signature and credentials of the staff providing the service.
- A documented discharge plan shall be discussed with the beneficiary and included in the record.

Service Limitations

- SACOT cannot be billed during the same authorization as SA Intensive Outpatient Program, all detoxification services levels (with the exception of Ambulatory Detoxification) or Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Social Setting Detox

Social Setting Detoxification is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal symptoms sufficiently severe to require 24-hour structure and support. The service is characterized by its emphasis on peer and social support. Established clinical protocols are followed by staff to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to the appropriate levels of care.

A comprehensive clinical assessment is one mechanism to demonstrate medical necessity for a service and to assess and identify an individual's needs. For state-funded services, a service order is recommended. Providers shall coordinate with the LME-MCO regarding their requirements for service orders.

Admission Criteria

- The individual is eligible for this service when all of the following criteria are met:
    - There is a substance use disorder diagnosis present.
    - The individual meets ASAM Level 3.2-WM criteria.

Continuing Stay and Discharge Criteria

- The individual continues in Social Setting Detoxification until:
    - Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
    - The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Service Delivery

- The expected outcome of this service is abstinence and reduction in any psychiatric symptoms (if present).
- Documentation Requirements
    - The minimum standard is a daily full service note for each day of Social Setting Detoxification that includes:
        - individual's name;
        - service record number;
        - date of service;
        - purpose of contact;
        - a description of the provider's interventions;
        - time spent performing the intervention;
        - effectiveness of interventions; and
        - signatures and credentials of staff providing the service.

Service Limitations

- This service may not be billed the same day as any other mental health or substance abuse service except CST and ACTT.

Non-Hospital Medical Detoxification

Non-Hospital Medical Detoxification is an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols.

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

Admission Criteria

- The beneficiary is eligible for this service when all the following criteria are met:
  - There is a substance use disorder diagnosis present; and
  - Meets ASAM Level 3.7-WM criteria.

Continued Stay and Discharge Criteria

- The beneficiary continues in Non-Hospital Medical Detoxification until ANY of the following criteria are met:
  - Withdrawal signs and symptoms are sufficiently resolved the beneficiary can be safely managed at a less intensive level of care; or
  - The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

- The expected outcome of this service is abstinence and reduction in any psychiatric symptoms if present.

Medically Supervised Detox Crisis Stabilization

Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization is an organized service delivered by medical and nursing professionals that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Beneficiaries are often in crisis due to co-occurring severe mental disorders (e.g. acutely suicidal or severe mental health problems and co-occurring substance use disorder) and need short-term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis. The service has restraint and seclusion capabilities. Established clinical protocols are followed by staff to identify beneficiaries with severe biomedical conditions who need medical services beyond the capacity of the facility and to transfer such beneficiaries to the appropriate level of care.

A service order for Medically Supervised or ADATC Detoxification Crisis Stabilization must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Admission Criteria

- The beneficiary is eligible for this service when all the following criteria are met:
  - There is a substance use disorder diagnosis present; and
  - Meets ASAM Level 3.9-WM criteria (NC).

Continued Stay and Discharge Criteria

- The beneficiary continues in Medically Supervised or ADATC Detoxification Crisis Stabilization until ANY of the following criteria are met:
  - Withdrawal signs and symptoms are sufficiently resolved that the beneficiary can be safely managed at a less intensive level of care;

- The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated;
- The addition of other clinical services is indicated.

Expected Outcomes

- The expected outcome of this service is abstinence and reduction in any psychiatric symptoms (if present).

References

North Carolina References

North Carolina Medicaid Division of Health Benefits. (2023). Behavioral Health Clinical Coverage Policies, North Carolina Medicaid website: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies.

EPSDT Service Description, Child First, State of North Carolina, October 24, 2019.

Revision History

Date	Summary of Changes
05/08/2021	Version 1
08/10/2021	Version 2: Revised with Child First Criteria
10/18/2022	Annual Review
10/17/2023	Annual Review