



United Behavioral Health

Supplemental Clinical Criteria: North Carolina Medicaid

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INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*¹ 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 of California ("Optum-CA")).

¹ **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

Other *Clinical Criteria*² may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®³. 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. 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. If 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.

Covered services are medically necessary⁴ defined in North Carolina as:

- Those Covered Services, including professional services or supplies which are
 - Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
 - Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease, or its symptoms;
 - Within generally accepted standards of medical care in the community; and
 - Not solely for the convenience of the Member, the Member's family or Provider

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.*

Admission Criteria

- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
- OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

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.

² Clinical Criteria

(ASAM Criteria) Criteria used to make medical necessity determinations for substance-related disorder benefits.

(Level of Care Utilization System-LOCUS) Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for adults ages 19 and older.

(Child and Adolescent Service Intensity Instrument-CASII)-Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

(Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children ages 0-5.

³ Optum is a brand used by United Behavioral Health and its affiliates.

⁴ North Carolina Definition of Medically Necessary Services or Supplies N.C. Gen. Stat. § 58-50-61

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 devastating 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 age 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. The assessment results in the issuance of a Diagnostic Assessment report with a recommendation regarding whether the member meets target population criteria and includes a recommendation for Enhanced Benefit services that provides the basis for the development of the PCP. For substance use-focused Diagnostic Assessment, the designated diagnostic tool specified by DMH (e.g., Substance Use Disorders Diagnostic Schedule (SUDDS) IV, Addiction Severity Index (ASI), Substance Abuse Subtle Screening Inventory (SASSI) for specific substance use disorder benefit plan populations (i.e., Work First, Driving While Intoxicated (DWI), etc. must be used. In addition, any elements included in this service definition that are not covered by the tool must be completed.*

- The Diagnostic Assessment must include all the following elements:
 - A chronological general health and behavioral health history (includes both mental health and substance use) of the member's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
 - Biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
 - A description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions; and current medications;
 - A strengths or problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
 - Diagnoses from the dsm-5, or any subsequent editions of this reference material, including mental health, substance use disorder and or intellectual/developmental disability as well as physical health conditions and functional impairment;
 - Evidence of an interdisciplinary team progress notes that documents the team's review and discussion of the assessment;
 - A recommendation regarding target population eligibility; and
 - Evidence of member participation including families, or when applicable, guardians or other caregivers
- 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.
- 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 CCS or 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.
- An initial Diagnostic Assessment may be performed by a Diagnostic Assessment team for each member being considered for receipt of services in the mental health, developmental disabilities, or substance abuse Enhanced Benefit package.

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.

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; and

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.

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.*

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.
 - B. Beneficiary exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (e.g., assaults with or without weapons, provocations of fights, gross aggressive over-reactivity to minor irritants, harming animals or is threatening same with likelihood of acting on the threat. This behavior should be attributable to the beneficiary's specific DSM-5, or any subsequent editions of this reference material, diagnosis and can be treated only in a hospital setting; or

- 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.
- Need for medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen, including forced administration of medication. This usually would be indicated by one of the following:
 - Beneficiary whose diagnosis and clinical picture is unclear and who requires 24-hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.
 - Beneficiary is involved in the legal system (e.g., in a detention or training school facility) and manifests psychiatric symptoms (e.g., psychosis, depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs; and
- A provider team shall certify that the beneficiary meets each of the certification of need requirements listed at 42 CFR 441. 152.

Continued 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 21 years of age in a psychiatric hospital or in a psychiatric unit of a general hospital, and to beneficiaries aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital; and
 - 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.

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

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.

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:

- 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;
- 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.

PROFESSIONAL TREATMENT SERVICES IN FACILITY BASED CRISIS 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.
- Concurrent review is conducted after the first 7 days and all utilization review activity is documented in the provider's service plan.

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:
 - 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

- The responsible provider and the treatment team complete the initial evaluation commensurate with the member's needs, no later than 3 treatment days after admission.
- During admission, a psychiatrist is available to consult with the program during and after normal program hours.

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: *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 as defined below. Services that treat or address ASD under this state plan are available only for the following beneficiaries: infants, children and adolescents age 0 to up to 21st birthday. Services that treat or address ASD will be provided to all individuals (age 0 to up to 21st birthday) who meet the medical necessity criteria for receipt of the service(s).

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 of 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 may be 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

- RB-BHT services are provided under a prior authorized treatment plan that has measurable goals over a specific timeline for the specific individual being treated developed by a licensed Qualified Autism Service Provider (LQASP).
- The treatment plan shall be reviewed no less than once every six months by a Licensed Qualified Autism Service Provider (LQASP) and modified whenever appropriate.
- Extension of service authorization must be received to continue coverage of the service.

Discharge Criteria

Transition and discharge planning from a treatment program shall include a written plan that specifies details for monitoring and follow-up as is appropriate for the individual and family/caregiver.

Service Delivery

- 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, and Preventive Services under Other Diagnostic, Screening, Preventive, Treatment, and rehabilitative Services;
- Observation and Direction Performing Provider's observation and direction of the BCaBA or Technician, which is reimbursed only when: (A) the Performing Provider is in the same location as both the individual and the BCaBA or technician and (B) 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.

TARGETED CASE MANAGEMENT

Targeted Case Management: *A community-based program in which a behavioral health professional or trained peer assists members who are at risk of being underserved in their efforts to identify, access, and utilize medical, behavioral health, or social services, or to otherwise achieve recovery and resiliency goals. The course of treatment is focused on addressing the member's condition to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.*

Targeted Case Management is a form of case management services provided only to specific classes of members, or to members who reside in specified areas.

Case Management may be mobile or delivered in an outpatient treatment setting.

Case Management services vary in intensity, frequency, and duration in order to support the member's ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

Admission Criteria

- The member's condition indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
 - The member requires assistance with navigating the system of care.
 - The member requires assistance with accessing transportation services, employment services, childcare, or other community resources.

Service Delivery

- The responsible Case Manager, in conjunction with the treatment team, completes an initial evaluation of the member's case management needs upon admission.
- The responsible Case Manager, in conjunction with the treatment team and, whenever possible, the member, develops a service plan that includes a description of the following:
 - The member's recovery and resiliency goals;
 - Strengths;
 - Problems;
 - Specific and measurable goals for each problem;

- Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the initial clinical evaluation.
- With the member's permission, the Case Manager advocates for the member by sharing feedback about the member's experience with the treatment provider, as well as agencies or other programs with which the member is involved.

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 age 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.*

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.

Continued 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).

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 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).

OUTPATIENT OPIOID TREATMENT

Outpatient Opioid Treatment is a service designed to offer the beneficiary an opportunity to effect constructive changes in his lifestyle by using methadone or other drug approved by the Food and Drug Administration (FDA) for the treatment of opiate addiction in conjunction with the provision of rehabilitation and medical services. It is a tool in the detoxification and rehabilitation process of an opiate-dependent individual.

Admission Criteria

The beneficiary is eligible for this service when all the following criteria are met:

- A DSM-5 (or any subsequent editions of this reference material) diagnosis of a severe Opioid Use Disorder;
- American Society for Addiction Medicine (ASAM) for Opioid Treatment Services (OTS) level of care is met; and
- Service is a part of an aftercare planning process (time-limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service.

Continued Service 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 service plan or the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains; OR
- The beneficiary meets any of the specifications listed in The ASAM Criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opioid Treatment Services.
- Authorization by NC Medicaid's designated contractor or LME-MCO is required.
- Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the Provider's Service Plan.

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, discharge 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 Maintenance Criteria

If the beneficiary is functioning effectively with this service and discharge would otherwise be indicated, Opioid Treatment 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 ONE of the following:

- history of regression in the absence of Opioid Treatment is documented in the beneficiary record; or
- presence of a DSM-5 (or any subsequent editions of this reference material) diagnosis that would necessitate a disability management approach, in the event that there is epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

REFERENCES

North Carolina References

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REVISION HISTORY

Date	Action/Description
5/8/21	• Version 1 (Draft)
8/10/21	• Revised with Child First Criteria