

Transforming Lives. Building Community Well-Being.

2024-2025 Medicaid Acute Behavioral Health Services Benefit Plan

Service Code(s):	Services Included (Sorted by Alphabetical Order):
160	Acute and Subacute Services Provided in an Institute for Mental Disease (Non-State Facilities and State ADATCs)
160	Acute and Subacute Services Provided in an Institute for Mental Disease (State Facilities, excluding State ADATCs)
T2016 U5, T2016 U6	Behavioral Health Crisis Assessment and Intervention
S9484HA	Facility-Based Crisis Service for Children and Adolescents
Y2343	Inpatient Behavioral Health Services: Behavioral Health Treatment Milieu Therapy
100	Inpatient Behavioral Health Services: Inpatient Hospital Psychiatric Treatment (MH)
100, 160	Inpatient Behavioral Health Services: Medically Managed Intensive Inpatient Services (Using DRG)
100, 160	<u>Inpatient Behavioral Health Services: Medically Managed Intensive Inpatient Withdrawal Management Services (Using DRG)</u>
H2011	Mobile Crisis Management
S9484	Professional Treatment Services in Facility-Based Crisis Program

Codes / modifier combinations not mentioned for specialized services will be found within contracts.

For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.

When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.





2024-2025 Medicaid Acute BH Service Benefit Plan

Inpatient Behavioral Health Services

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

For members with substance use disorder, Inpatient Behavioral Health Services cover:

- Medically Managed Intensive Inpatient Services- Adolescent
- Medically Managed Intensive Inpatient Services- Adult
- Medically Managed Intensive Withdrawal Management Services- Adult

For members with mental health disorders, Inpatient Behavioral Health Services cover:

- Inpatient Psychiatric Hospitalization- Child and Adolescent
- Inpatient Psychiatric Hospitalization- Adult

Definitions and Abbreviations

- ACT: Assertive Community Treatment
- ADATC: Alcohol and Drug Abuse Treatment Center
- American Society of Addiction Medicine Criteria: a treatment criterion for addictive, substance-related, and co-occurring condition
- CADT: Child and Adolescent Day Treatment
- CST: Community Support Team
- DRG: Diagnosis-Related Group
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid member under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).
- H&P: History and Physical
- IIH: Intensive In-Home Services
- IMD: Institute of Mental Disease
- Medication Assisted Treatment (MAT): the use of medications, in combination with counseling and behavioral therapist, to provide a "whole patient' approach to the
 treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration, and MAT programs are clinically driven and
 tailored to meet each member's needs.
- MST: Multisystemic therapy
- MCSART: Medical Community Substance Abuse Residential Treatment
- NMCSART: Non-Medical Community Substance Abuse Residential Treatment
- Psych Eval: Psychiatric Evaluation
- SACOT: Substance Abuse Comprehensive Outpatient
- SAIOP: Substance Abuse Intensive Outpatient
- Tx: Treatment

Created: 07-30-2024



2024-2025 Medicaid Acute BH Service Benefit Plan

General Information for State Psychiatric Hospitals and ADATCs

- Except for Emergency Services, facilities must verify Member eligibility. For Emergency Services, facilities shall verify Member eligibility no later than the next business day after the Member is stabilized or the facilities learning the individual may be a Member, whichever is later.
- Facilities must initiate the discharge planning process promptly following an individual's admission to the facility.
- Provide the Discharge Summary to the selected community provider(s) at the earliest practicable time, within at least 72 hours after discharge.
- Where applicable, Trillium will work cooperatively with the facility regarding a discharge service order addressing the members individual needs prior to discharge and make best efforts to authorize and/or deny services requested to begin upon discharge within three (3) business days after receipt of the discharge service order.
- Upon the denial of a requested authorization, Trillium may inform the member's attending physician or ordering provider of the availability of a peer-to-peer conversation within one business day.

Service &	Brief Service	Auth Submission	And advantage Barrantage	0
Code	Description	Requirements	Authorization Parameters	Source(s)
	This service	Pass-Through Period:	Length of Stay:	Clinical Coverage
Acute and	provides 24-hour	Prior authorization is not required	1. Members receiving tx for MH diagnoses are limited to no more	Policy No: 8-B,
Subacute	access to	for the first 72 hours of service.	than 15 authorized days each calendar month. For admissions	<u>Inpatient</u>
Services	continuous		spanning two consecutive months, the total length of stay may	Behavioral Health
Provided in	intensive	Initial Requests (after pass-	exceed 15 days, but no more than 15 days may be authorized in	<u>Services</u>
an Institute	evaluation and	through):	each month. There is not a day limit for members receiving SU	
for Mental	treatment	1. TAR: prior authorization required	services.	July 2012 MCD
Disease	delivered in an	within the first 72 hours of service	2. For State ADATC's, the initial authorization will be for at least 7	Bulletin:
	Institute for Mental	initiation.	days.	<u>Authorization</u>
(Non-State	Disease (IMD) for	2. CCA or DA: Required. See CCP	3. Reauth requests must be submitted prior to the end of the	Requests by
Facilities and	acute and	Section 7.5 for additional	current auth. A late submission resulting in unauthorized days	<u>Psychiatric</u>
<u>State</u>	subacute inpatient	requirements. An H&P/ Initial	requires splitting the stay for claims payment purposes.	Inpatient Acute
<u>ADATC</u>)	psychiatric	Psychiatric Evaluation may satisfy	4. Retrospective auths due to late submissions is not permitted.	<u>Care</u>
0 - 1 - (-) - 400	disorders. Delivery	this requirement.	Halfa Dan Panal and Landla ad Idal (Included)	<u>Providers</u>
Code(s): 160	of service is	3. Service Order: Required, signed	<u>Units</u> : Per diem based on the midnight bed count	IOD # 1077.
	provided by	by a physician, LP, PA, or NP. A	Arra Onacco Adulta anad O4 C4	JCB #J277:
	nursing and	signed H&P/ Initial Psychiatric Eval	Age Group: Adults aged 21-64	Authorization
	medical professionals	meets this requirement. 4. Service Plan: Required	Place of Service: Institute for Mental Disease (IMD)	Requests for Services When a
	under the	5. Submission of all records that	riace of Service. Institute for interital Disease (IIVID)	Third-Party Payer
	supervision of a	support the individual has met the	Service Specifics, Limitations/ Exclusions (not all inclusive):	is Primary
	psychiatrist.	medical necessity criteria.	1. The case management component of IIH, MST, CST, ACT,	<u>is Filliary</u>
	Providers must	medical necessity chiena.	SAIOP, SACOT & CADT can be provided to those admitted to or	JCB #J265:
	follow the	Reauthorization Requests:	discharged from this service. Support provided should be delivered	Clarification of
	requirements for	1. TAR: prior authorization required.	in coordination with the Inpatient facility.	Services in an
	inpatient level of	2. Updated Tx Plan/ PCP: Required	2. Medicaid eligibility must be verified each time a service is	IMD
	care outlined in	3. Submission of applicable records	rendered.	
	Clinical Coverage	that support the member has met	3. Discharge Planning shall begin upon admission to this service.	JCB #J348: SUD
	Policy (CCP) 8-B,	the medical necessity criteria.	4. Prior authorization is not required for MCD BH Services rendered	IMD Clarification
	Inpatient	,	to Medicare/Medicaid dual eligible members or members with 3rd-	
	Behavioral Health		party insurance because MCD is the payer of last resort. When	APSM 45-2
	Services.		MCD becomes the primary payer, a primary payer auth denial/	Records
			exhaustion of benefits letter is submitted with the MCD TAR.	Management and
			5. Out-of-State emergency admissions do not require prior	Documentation
			approval. The provider must contact Trillium within one business	<u>Manuals</u>
			day of the emergency service or emergency admission.	

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
	This is an organized	Initial Requests:	Length of Stay:	Clinical Coverage
Acute and	service that provides	1. TAR: Required	1. Provider must submit a TAR covering the member's length of	Policy No: 8-B,
Subacute	intensive evaluation	2. I/DD Exception Form:	stay on the next business day following the Individual's	<u>Inpatient</u>
Services Provided	and treatment	Required per Diversion Law, if	discharge.	Behavioral Health
in an Institute for	delivered in an acute	applicable.	2. Member's that present directly to the facility as an emergency	<u>Services</u>
Mental Disease	care inpatient setting	3. CCA or DA: Required. See	commitment or as a self-referral, the facility shall submit a TAR	
	by medical and	CCP Section 7.5 for additional	by the next business day.	July 2012 MCD
(State Facilities,	nursing	requirements. An H&P/ Initial	3. Members receiving tx for MH diagnoses are limited to no more	Bulletin:
excluding State	professionals. This	Psychiatric Evaluation may	than 15 authorized days each calendar month. For admissions	Authorization
<u>ADATCs</u>)	service focuses on	meet this requirement.	spanning two consecutive months, the total length of stay may	Requests by
0 1 () 400	reducing acute	4. Service Order: Required,	exceed 15 days, but no more than 15 days may be authorized in	<u>Psychiatric</u>
Code(s): 160	psychiatric	signed by a physician, LP, PA,	each month. There is not a day limit for members receiving SU	Inpatient Acute
	symptoms through	or NP. A signed H&P/ Initial	services.	<u>Care</u>
	in-person, structured	Psychiatric Eval meets this	Huitas A suit nan day fan yn ta 45 days nan nawth	<u>Providers</u>
	group and individual	requirement.	<u>Units</u> : 1 unit per day for up to 15 days per month.	IOD # 1077.
	treatment.	5. Service Plan: Required	Are Creve, Adulto ared 24 C4	JCB #J277:
		6. Submission of all records	Age Group: Adults aged 21-64	Authorization Requests for
		that support the member has met the medical necessity	Place of Service: Institute for Mental Disease (IMD)	Services When a
		criteria. The state facility shall	Place of Service. Institute for Merital Disease (IMD)	Third-Party Payer
		provide Trillium with all	Service Specifics, Limitations/ Exclusions (not all inclusive):	is Primary
		necessary clinical information	Trillium will issue an auth decision within 14 days after receipt	<u>is i filliary</u>
		needed for the utilization	of the TAR.	JCB #J265:
		management process.	2. The case management component of IIH, MST, CST, ACT,	Clarification of
		management process.	SAIOP, SACOT & CADT can be provided to those admitted to or	Services in an
		Reauthorization Requests:	discharged from this service. Support provided should be	IMD
		Not applicable	delivered in coordination with the Inpatient facility.	<u></u>
			3. Medicaid eligibility must be verified each time a service is	JCB #J348: SUD
			rendered.	IMD Clarification
			4. Discharge Planning shall begin upon admission to this service.	
			5. Prior authorization is not required for MCD BH Services	APSM 45-2
			rendered to Medicare/Medicaid dual eligible members or	Records
			members with 3rd-party insurance because MCD is the payer of	Management and
			last resort. When MCD becomes the primary payer, a primary	Documentation
			payer auth denial/ exhaustion of benefits letter is submitted with	Manuals
			the MCD TAR.	

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
	This service is designed to	Initial & Concurrent Requests: No prior	Length of Stay & Units:	In-Lieu Of
Behavioral	provide triage, crisis risk	authorization is required for this service.	One unit = 1 event with a clinical	Behavioral Health
Health Crisis	assessment, evaluation,		assessment by a licensed clinician	Crisis Assessment
Assessment	and intervention within a	Other:	(required for billing).	and Intervention
and	Behavioral Health Urgent	1. Tier IV BHUC holds IVC designation and		Service Definition
Intervention	Care (BHUC) setting for	completes IVC First Evaluations.	Individuals receiving this service will be	
(BH-CAI)	members experiencing a	2. Within a BHUC setting, law enforcement is	evaluated, then stabilized and/or	APSM 45-2
	behavioral health crisis	available on site to maintain custody and facilitate	referred to the most appropriate level of	Records
Code(s):	meeting emergent or urgent	drop off by community first responders or other law	care.	Management and
	triage standards.	enforcement in instances where a petition has been		<u>Documentation</u>
T2016 U5 : At a	Individuals receiving this	filed or an IVC has been initiated.	Place of Service: Behavioral Health	<u>Manuals</u>
Tier III BHUC	service will be evaluated,	3. This BH-CAI service is comprised of four	Urgent Care (BHUC)	
	then stabilized and/or	elements. Central to it is the clinical assessment by		
T2016 U6 : At a	referred to the most	a licensed clinician. Without that component the	Level of Care: Members experiencing a	
Tier IV BHUC	appropriate level of care. A	service is not billable. Other core elements include a	behavioral health crisis with any	
	BHUC setting is an	triage determination, crisis intervention and	combination of MH, SUD and co-	
	alternative, but not a	disposition planning.	occurring BH/IDD issue	
	replacement, to a	4. BHUC services are either Tier III or Tier IV. A Tier		
	community hospital	III BHUC operates at least 12 hours per day 7 days	Age Group: Children, Adolescents &	
	Emergency Department.	a week, 365 days a year w/ at least 6 hours	Adults (Individuals 4 years or older)	
		occurring after 4:00 PM each day. A Tier IV BHUC		
		is open 24 hours a day, 7 days a week, 365 days a	Service Specifics, Limitations/	
		year. This service is designed to be completed	Exclusions (not all inclusive): None	
		during the defined business hours.	noted	
		5. For community discharges, it is expected the		
		consumer will receive a copy of the crisis plan and		
		follow up instructions at the time of release.		

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
Oode	This is a service that	Initial Requests:	Length of Stay & Units:	Clinical
Facility-	provides an	1. TAR: Required, submitted within 2 business days of admission.	1. Up to 7 days (168 units) per auth	Coverage
Based Crisis	alternative to	2. Service Order: Required, signed by an MD/ DO, PA, NP, or	2. No more than 45 days in a 12-	Policy No: 8A-
Service for	hospitalization for an	licensed psychologist.	month period (EPDST exception	2, Facility-
Children	eligible member who	3. Pre-Admission Nurse Screening: Required, conducted by an	applies).	Based Crisis
and	presents with	RN or LPN under the supervision of an RN to determine medical	3. One unit = 1 hour	Service for
Adolescents	escalated behavior	appropriateness for this LOC and to rule out acute or severe		Children and
	due to a mental	chronic comorbidities that could require complex medical	Level of Care: If SU applies, ASAM	Adolescents
Code(s):	health, intellectual or	intervention in a higher LOC	Level 3.7	
S9484HA	development	4. Clinical Assessment: Required at the time of admission. A full		PCP Guidance
	disability or	CCA must be completed prior to DC.	Age Group: Children (ages 6-17).	Documents &
	substance use	5. Nursing Assessment: Required within 24 hours of admission	Members 18 to 21 are eligible for FBC	<u>Templates</u>
	disorder and requires	6. Psychiatric Evaluation: Required within 24 hours of admission	Services for Adults.	
	treatment in a 24-	7. Tx plan: Required to direct tx and interventions during the stay.		APSM 45-2
	hour residential	Must include the goal(s), objectives, tx interventions and the	Place of Service: Licensed crisis	Records
	facility. Under the	individual responsible for carrying out the intervention.	settings	<u>Management</u>
	direction of a	8. Care Coordination Referral: If not already linked with a care		<u>and</u>
	psychiatrist, this	coordinator, a referral should be made for care coordination	Service Specifics, Limitations/	<u>Documentation</u>
	service provides	within 24 hours of admission.	Exclusions (not all inclusive):	<u>Manuals</u>
	assessment and	9. Submission of applicable records that support the member has	1. Within 24-hrs of admission, provider	
	short-term	met the medical necessity criteria.	must contact the MCO to determine if	
	therapeutic		the member is enrolled with another	
	interventions	Reauthorization Requests:	service provider or if the member is	
	designed to prevent	1. TAR: Required	receiving care coordination. If the	
	hospitalization by de-	2. Updated Tx Plan: to include the goal(s), objectives, treatment	member is not already linked with a	
	escalating and	interventions and who is responsible for each.	care coordinator, a referral must be	
	stabilizing acute	3. Discharge/ Aftercare Plan: to include: a) the date, time and	made.	
	responses to crisis	location of first follow up appointment; b) the behavioral health	2. MCD will not cover Facility-Based	
	situations.	services to be provided; c) living and educational or vocational	Crisis Service delivered to a child or	
		arrangements; d) the members current treatment and care	adolescent stepping down from an	
		coordination needs; and. e) diagnosis and discharge medications 4. Crisis Plan: to includes interventions to prevent readmission	inpatient level of care. 3. IDD Exclusion Rules apply [see	
		into a crisis setting	NCGS 122C-261(f), 122C-262(d), and	
		5. Submission of applicable records that support the member has	122C 263(d)(2)]	
		met the medical necessity criteria.	1220 200(u)(2)	
		mot the medical hoocssity entend.		

Behavioral Health Services: Behavioral Health Services: Treatment Milieu Therapycriteria for continued acute state in an inpatient psychiatric facility are met, reimbursement may be provided for members through the age of 17 for Criterion 5 in an Inpatient Inpatient Psychiatric are met, reguirement.criteria for continued acute state in an inpatient in an inpatient psychiatric facility at a post-acuterequired. 2. Care Coordination Referral: On-going (at least weekly) coordination between the facility and the MCO satisfies this requirement. 3. Attending Physician Documentation: A) Documentation: A) Documentation of the member's history of sudden decompensation or measurable regression, and B) That the member currently experiences weakness in their environmental support systemLinits: Per diem based on the midnight bed countLinits: Per diem based on the midnig	Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
paid at a residential rate established by NC Medicaid if the facility and program services are appropriate for the member's treatment needs Description of applicable records that support the member has met the medical necessity criteria. Display 1 Inpatient facility. 2. Medicaid eligibility must be verified each time a service is rendered. 3. Service is EPSDT eligible, but this does not eliminate the requirement for prior approval. A. Discharge Planning shall begin upon admission to this service. 5. Medicaid shall not cover services in a freestanding psychiatric hospital for members over 21 or less than 65 years of age for mental health disorders. 6. Out-of-State emergency admissions do not require prior approval. The provider must contact Trillium within one business day of the emergency service or emergency admission. Apply 2012 M Bulletin: Authorizati Psychiatric hospital for members over 21 or less than 65 years of age for mental health disorders. 6. Out-of-State emergency admissions do not require prior approval. The provider must contact Trillium within one business day of the emergency service or emergency admission.	Inpatient Behavioral Health Services: Behavioral Health Treatment Milieu Therapy Code(s): Y2343: Criterion 5 in an Inpatient	In the event that not all of the criteria for continued acute state in an inpatient psychiatric facility are met, reimbursement may be provided for members through the age of 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at a residential rate established by NC Medicaid if the facility and program services are appropriate for the member's	All Requests: 1. TAR: prior authorization required. 2. Care Coordination Referral: On-going (at least weekly) coordination between the facility and the MCO satisfies this requirement. 3. Attending Physician Documentation: A) Documentation: A) Documentation of the member's history of sudden decompensation or measurable regression, and B) That the member currently experiences weakness in their environmental support system which is likely to trigger a decomp or regression 4. Submission of applicable records that support the member has met the medical	1. Initial requests: Up to 7 units per auth 2. Reauthorization requests: Up to 7 units per auth. Reauth requests must be submitted prior to the end of the current auth. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. Units: Per diem based on the midnight bed count Age Group: Children through age 17 Place of Service: This service may be provided at a psychiatric hospital or on an inpatient psychiatric unit within a licensed hospital licensed as inpatient psychiatric hospital beds or in State operated facilities. Service Specifics, Limitations/ Exclusions (not all inclusive): 1. The case management component of IIH, MST, CST, ACT, SAIOP, SACOT & CADT can be provided to those admitted to or discharged from this service. Support provided should be delivered in coordination with the Inpatient facility. 2. Medicaid eligibility must be verified each time a service is rendered. 3. Service is EPSDT eligible, but this does not eliminate the requirement for prior approval. 4. Discharge Planning shall begin upon admission to this service. 5. Medicaid shall not cover services in a freestanding psychiatric hospital for members over 21 or less than 65 years of age for mental health disorders. 6. Out-of-State emergency admissions do not require prior approval. The provider must contact Trillium within one business day of the emergency	Clinical Coverage Policy No: 8-B, Inpatient Behavioral Health Services Instructions for Use of Service Needs/Discharge Planning Status Form Criterion #5 Service Needs/Discharge Planning Status Form July 2012 MCD Bulletin: Authorization Requests by Psychiatric Inpatient Acute Care Providers APSM 45-2 Records Management

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
	This is an	Pass-Through Period:	Length of Stay:	Clinical
Inpatient	organized service	Prior authorization is not required	1. Reauth requests must be submitted prior to the end of the current auth.	Coverage
Behavioral	that provides	for the first 72 hours of service.	A late submission resulting in unauthorized days requires splitting the stay	Policy No: 8-B,
Health	intensive		for claims payment purposes. Retrospective auths due to late	Inpatient
Services:	evaluation and	Initial Requests (after pass-	submissions is not permitted.	<u>Behavioral</u>
Inpatient	treatment	through):	2. For state psychiatric hospitals, the initial auth will be for a minimum of	Health Services
Hospital	delivered in an	1. TAR: prior authorization	10 days (including the pass-through days).	
Psychiatric	acute care	required within the first 72 hours of		July 2012 MCD
Treatment	inpatient setting	service initiation.	<u>Units</u> : Per diem based on the midnight bed count	Bulletin:
(MH)	by medical and	Certificate of Need (CON):		<u>Authorization</u>
	nursing	Required at admission to a	Age Group: Children, Adolescents & Adults	Requests by
Code(s):	professionals	freestanding psych hospital or		<u>Psychiatric</u>
100:	under the	within 14 calendar days of an	Place of Service: This service may be provided at a psychiatric hospital or	Inpatient Acute
Inpatient	supervision of a	emergency admission for	on an inpatient psychiatric unit within a licensed hospital licensed as	<u>Care</u>
Behavioral	psychiatrist. This	members under 21.	inpatient psychiatric hospital beds or in State operated facilities.	<u>Providers</u>
Health	<u>service is</u>	3. CCA or DA: Required. An H&P/		
Services	<u>designed to</u>	Initial Psychiatric Evaluation may	Service Specifics, Limitations/ Exclusions (not all inclusive):	JCB #J277:
	<u>provide</u>	satisfy this requirement.	1. The case management component of IIH, MST, CST, ACT, SAIOP,	Authorization
	continuous	4. Service Order: Required, signed	SACOT & CADT can be provided to those admitted to or discharged from	Requests for
	treatment for	by a physician, LP, PA, or NP. A	this service. Support provided should be delivered in coordination with the	Services When
	<u>members with</u>	signed H&P/ Initial Psychiatric Eval	Inpatient facility.	a Third-Party
	acute psychiatric	meets this requirement.	2. Medicaid eligibility must be verified each time a service is rendered.	Payer is
	<i>problems</i> . This	5. Service Plan: Required	3. Service is EPSDT eligible, but this does not eliminate the requirement	<u>Primary</u>
	service focuses	6. Submission of all records that	for prior approval.	A D C M 4 F 0
	on reducing	support the individual has met the	4. Discharge Planning shall begin upon admission to this service.	APSM 45-2
	acute psychiatric	medical necessity criteria.	5. Medicaid shall not cover services in a freestanding psychiatric hospital for members over 21 or less than 65 years of age for mental health	Records Management
	symptoms through in-	Reauthorization Requests:	disorders.	Management and
	•	1. TAR: prior authorization	6. Prior authorization is not required for MCD BH Services rendered to	Documentation
	person, structured group	required.	Medicare/Medicaid dual eligible members or members with 3rd-party	Manuals
	and individual	2. Updated Tx Plan/ PCP:	insurance because MCD is the payer of last resort. When MCD becomes	<u>iviariuais</u>
	treatment.	Required	the primary payer, a primary payer auth denial/ exhaustion of benefits	CON: Medicaid
	ucaunent.	3. Submission of applicable	letter is submitted with the MCD TAR.	Inpatient
		records that support the member	7. Out-of-State emergency admissions do not require prior approval. The	Psychiatric
		has met the medical necessity	provider must contact Trillium within one business day of the emergency	Services Under
		criteria.	service or emergency admission.	Age 21
			1	<u>go = 1</u>

Service &	Brief Service	Auth Submission		
Code	Description	Requirements	Authorization Parameters	Source(s)
0000	This is an ASAM	Pass-Through Period:	Length of Stay:	Clinical Coverage
Inpatient	Level 4 for	Prior authorization is not required for	1. Initial requests (after the pass-through): Up to 10 units per	Policy No: 8-B,
Behavioral	adolescent and	the first 72 hours of service.	auth.	Inpatient Behavioral
Health	adult members		2. Reauthorization requests: Up to 10 units per auth. Reauth	Health Services
Services:	whose acute	Initial Requests (after pass-	requests must be submitted prior to the end of the current auth. A	<u></u>
Medically	biomedical,	through):	late submission resulting in unauthorized days requires splitting	July 2012 MCD
Managed	emotional,	1. TAR: prior authorization required	the stay for claims payment purposes.	Bulletin: Authorization
Intensive	behavioral and	within the first 72 hours of service	3. Retrospective auths due to late submissions is not permitted.	Requests by
Inpatient	cognitive	initiation.		Psychiatric Inpatient
Services	problems are so	2. CCA or DA: Required, an initial	Units : Per diem based on the midnight bed count	Acute Care
(Using DRG)	severe that they	assessment must be completed	<u> </u>	Providers
`	require primary	within 72 hours of admission and	Age Group: Adolescent and Adult	·
Code(s):	medical and	updated prior to discharge to		JCB #J277:
100: Inpatient	nursing care.	determine the next clinically	Place of Service: This service may be provided in a licensed	Authorization
Behavioral	The outcome of	appropriate level of care. See CCP	community hospital or a facility licensed under 10A NCAC 27G	Requests for
Health	this level of care	Section 7.5 for specific requirements.	.6000, unless provided by an IHS or compact operated by a	Services When a
Services	is stabilization of	3. Certificate of Need (CON):	Federally Recognized Tribe as allowed in 25 USC 1621t and	Third-Party Payer is
	acute signs and	Required at admission to a	1647a, or provided by a State or Federally operated facility as	<u>Primary</u>
160: Inpatient	symptoms of	freestanding psych hospital or within	allowed by §122C-22. (a)(3). This substance use disorder service	
Behavioral	substance use,	14 calendar days of an emergency	may be provided in an IMD.	JCB #J265:
Health	and a primary	admission for members under 21.		Clarification of
Services in an	focus of the	4. Service Order: Required, signed	Service Specifics, Limitations/ Exclusions (not all inclusive):	Services in an IMD
IMD	treatment plan	by a physician, LP, PA, or NP. A	1. The case management component of IIH, MST, CST, ACT,	
	should be	signed H&P/ Initial Psychiatric Eval	SAIOP, SACOT & CADT can be provided to those admitted to or	JCB #J348: SUD IMD
	coordination of	meets this requirement.	discharged from this service. Support provided should be	<u>Clarification</u>
	care to ensure a	5. Service Plan/ Plan of Care/ Tx	delivered in coordination with the Inpatient facility.	
	smooth	Plan: Required	2. Discharge planning shall begin upon admission to the service.	APSM 45-2 Records
	transition to the	6. Submission of applicable records	3. This level of care must be capable of initiating or continuing	Management and
	next clinically	that support the member has met the	any MAT that supports the member in their recovery from	<u>Documentation</u>
	appropriate level	medical necessity criteria.	substance use.	<u>Manuals</u>
	of care.		4. Prior authorization is not required for MCD BH Services	
		Reauthorization Requests:	rendered to Medicare/Medicaid dual eligible members or	CON: Medicaid
		1. TAR: prior authorization required.	members with 3rd-party insurance because MCD is the payer of	Inpatient Psychiatric
		2. Updated Tx Plan/ PCP: Required	last resort. When MCD becomes the primary payer, a primary	Services Under Age
		3. Submission of applicable records that support the member has met the	payer auth denial/ exhaustion of benefits letter is submitted with the MCD TAR.	<u>21</u>
		medical necessity criteria.	5. For ADATCs: For members under the age of 21, admission	
		ĺ	authorization shall be requested by the facility the next business	
Created: 07-30-	2024	Please refer to U	M notes on approvals and denials	Page 10 of 15

day following admission if the individual presents directly to the facility, by submitting a completed Non-Covered State Medicaid Plan Services Request Form to the Health Plan. To request reauthorization, the ADATC shall submit a completed Electronic Authorization Request to the Health Plan prior to the expiration of	Trillium HEALTH RESOURCES	2024-2025 Medicaid Acute BH Service Benefit Plan	
the admission authorization. The form shall be submitted by the ADATC on the last covered day of the existing authorization (or the previous business day if the last covered day occurs on a weekend or holiday).		facility, by submitting a completed Non-Covered State Medicaid Plan Services Request Form to the Health Plan. To request re- authorization, the ADATC shall submit a completed Electronic Authorization Request to the Health Plan prior to the expiration of the admission authorization. The form shall be submitted by the ADATC on the last covered day of the existing authorization (or the previous business day if the last covered day occurs on a	



Service &	Brief Service	Auth Submission	Authorization Donomatons	Co(a)
Code	Description	Requirements	Authorization Parameters	Source(s)
	This is an ASAM	Pass-Through Period:	Length of Stay:	Clinical Coverage
Inpatient	Level 4-WM for	Prior authorization is not required for	1. Initial requests (after the pass-through): Up to 7 units per auth,	Policy No: 8-B,
Behavioral	adult members	the first 72 hours of service.	with a minimum of 7 days for an initial ADATC services request.	Inpatient Behavioral
Health	whose withdrawal		2. Reauthorization requests: Up to 7 units per auth. Reauth	Health Services
Services:	signs and	Initial Requests (after pass-	requests must be submitted prior to the end of the current auth. A	
Medically	symptoms are	through):	late submission resulting in unauthorized days requires splitting	July 2012 MCD
Managed	sufficiently	1. TAR: prior authorization required	the stay for claims payment purposes.	Bulletin:
Intensive	severe to require	within the first 72 hours of service	3. Retrospective auths due to late submissions is not permitted.	Authorization
Inpatient	primary medical	initiation.		Requests by
Withdrawal	and nursing care,	2. CCA or DA: Required, an initial	Units : Per diem based on the midnight bed count	Psychiatric Inpatient
Management	<u>24-hour</u>	assessment must be completed		Acute Care
Services	observation,	within 72 hours of admission and	Age Group: 18 and older	<u>Providers</u>
(Using DRG)	monitoring, and	updated prior to discharge to		
	<u>withdrawal</u>	determine the next clinically	Place of Service: May be provided in a licensed community	JCB #J277:
Code(s):	<u>management</u>	appropriate level of care. See CCP	hospital or a facility licensed under 10A NCAC 27G .6000 unless	<u>Authorization</u>
100: Inpatient	services in a	Section 7.5 for specific requirements.	provided by an IHS or compact operated by a Federally	Requests for
Behavioral	<u>medically</u>	3. Certificate of Need (CON):	Recognized Tribe as allowed in 25 USC 1621t and 1647a, or	Services When a
Health	<u>monitored</u>	Required at admission to a	provided by a State or Federally operated facility as allowed by	Third-Party Payer is
Services	inpatient setting.	freestanding psych hospital or within	§122C-22.(a)(3). This substance use disorder service may be	<u>Primary</u>
	The intended	14 calendar days of an emergency	provided in an IMD.	
160: Inpatient	outcome of this	admission for members under 21.		JCB #J265:
Behavioral	level of care is to	4. Service Order: Required, signed	Service Specifics, Limitations/ Exclusions (not all inclusive):	Clarification of
Health	sufficiently	by a physician, LP, PA, or NP. A	1. The case management component of IIH, MST, CST, ACT,	Services in an IMD
Services in an	resolve the signs	signed H&P/ Initial Psychiatric Eval	SAIOP, & SACOT can be provided to those admitted to or	
IMD	and symptoms of	meets this requirement.	discharged from this service. Support provided should be	JCB #J348: SUD
	withdrawal so the	5. Service Plan/ Plan of Care/ Tx	delivered in coordination with the Inpatient facility.	IMD Clarification
	member can be	Plan: Required	2. Discharge planning shall begin upon admission to the service.	
	safely managed	6. Submission of applicable records	3. This level of care must be capable of initiating or continuing	APSM 45-2
	at a less	that support the member has met the	any MAT that supports the member in their recovery from	Records
	intensive level of	medical necessity criteria.	substance use.	Management and
	care.		4. Prior authorization is not required for MCD BH Services	<u>Documentation</u>
		Reauthorization Requests:	rendered to Medicare/Medicaid dual eligible members or	<u>Manuals</u>
		1. TAR: prior authorization required.	members with 3rd-party insurance because MCD is the payer of	
		2. Updated Tx Plan/ PCP: Required	last resort. When MCD becomes the primary payer, a primary	CON: Medicaid
		3. Submission of applicable records	payer auth denial/ exhaustion of benefits letter is submitted with	Inpatient Psychiatric
		that support the member has met the	the MCD TAR.	Services Under Age
		medical necessity criteria.	5. For ADATCs: For members under the age of 21, admission	<u>21</u>
			authorization shall be requested by the facility the next business	
Created: 07-30-2	024	Please refer to UM	notes on approvals and denials	Page 12 of 15

Trillium HEALTH RESOURCES	2024-2025 Medicaid Acute BH Service Benefit Plan
	day following admission if the individual presents directly to the facility, by submitting a completed Non-Covered State Medicaid Plan Services Request Form to the Health Plan. To request reauthorization, the ADATC shall submit a completed Electronic Authorization Request to the Health Plan prior to the expiration of the admission authorization. The form shall be submitted by the ADATC on the last covered day of the existing authorization (or the previous business day if the last covered day occurs on a weekend or holiday).



Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
	Mobile Crisis Management	Pass-Through Period:	<u>Units</u> : 1 unit = 15 minutes	Clinical
Mobile Crisis	(MCM)involves all support,	Prior authorization is not required for the first		Coverage Policy
Management	services and treatments	32 units of crisis services per episode.	Age Group: Children, Adolescents & Adults	No: 8A,
	necessary to provide			Enhanced
Code(s): H2011	integrated crisis response,	Initial (after pass-through) &	Place of Service: Community settings	Mental Health
	crisis stabilization	Reauthorization Requests:		
Triage and	interventions, and crisis	1. TAR: prior authorization required within 48	Service Specifics, Limitations/ Exclusions	APSM 45-2
Screening is	prevention activities. This	hours of exhausting unmanaged units.	(not all inclusive):	Records
Telehealth Eligible	service is designed to	Note: Clinical docs are only required if more	The crisis management provider must	<u>Management</u>
	rapidly assess crisis	than 8 additional units are requested.	contact the MCO to determine if the member	<u>and</u>
	situations and a member's	2. Service Note(s): Required	is enrolled with a provider that should be	<u>Documentation</u>
	clinical condition, to triage	3. ASAM: If applicable, the ASAM Score	involved with the response. Medicaid shall	<u>Manuals</u>
	the severity of the crisis,	must be supported with detailed clinical	not cover services when the service	
	and to provide immediate,	documentation on each of the six ASAM	unnecessarily duplicates another provider's	PCP Guidance
	focused crisis intervention	dimensions.	authorized service.	Documents &
	services which are	4. Person Centered Plan (PCP) Revision	2. Service shall be used to divert members	<u>Templates</u>
	mobilized based on the type and severity of crisis.	Recommendations: Required for those already receiving services, Mobile Crisis	from inpatient psychiatric and detoxification services.	
		Management (MCM) must recommend	3. Priority should be given to a member with a	
		revisions to existing crisis plan components	history of multiple crisis episodes or who are	
		in PCPs.	at substantial risk of future crises.	
		5. Submission of applicable records that		
		support the member has met the medical	Service Exclusions: May not be provided	
		necessity criteria.	concurrently w/: ACT, CST, IIH, MST,	
			MCSART, NMCSART, Withdrawal services,	
			Inpatient services, PRTF (Except on the day	
			of admission for Inpatient & PRTF).	



Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source(s)
	Service provides an	Pass-Through Period:	Length of Stay : This is a short-term service that	Clinical Coverage
Professional	alternative to	Prior authorization is not required for	cannot be provided for more than 45 days in a 12-	Policy No: 8A,
Treatment	hospitalization for adults	this service.	month period.	Enhanced Mental
Services in	(age 18 or older) who have		·	Health
Facility-Based	a mental illness or	Maintained in the Record (not all	<u>Units</u> : One unit = 1 hour, up to 24 hours in a 24-	
Crisis Program	substance use disorder.	inclusive):	hour period.	APSM 45-2
J	This can be provided in a	1. Service Order: Required and must	· ·	Records
Code(s): S9484	non-hospital setting for	be ordered by a primary care	Age Group: Adults (age 18 or older)	Management and
` '	members in crisis who	physician, psychiatrist, or a licensed		Documentation
	need short-term intensive	psychologist.	Place of Service: Licensed crisis settings	Manuals
	evaluation, treatment	2. Service Plan: Required and must		
	intervention or behavioral	be completed at the time the member	Service Specifics, Limitations/ Exclusions (not	PCP Guidance
	management to stabilize	is admitted to a service.	all inclusive): Provider will arrange for linkage to	Documents &
	acute or crisis situations.	3. Progress notes documenting	services for further tx or rehab upon discharge	Templates
		continued stay criteria.	from the Facility Based Crisis Service. Discharge	Tomplatoo
		4. CCA: required prior to discharge in	planning begins at the time of admission for all	
		order to document medical necessity.	MH and SU services. The step-down process	
		,	should afford the member a less restrictive level of	
			service without losing the focus of tx or	
			interventions required to facilitate continued	
			progress.	