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1.0 Description of the Procedure, Product, or Service

- a. Acute inpatient treatment represents the most intensive level of care. An inpatient admission requires twenty-four support of an acute care, secure and protected hospital setting. Twenty-four hour skilled nursing care, daily medical care, and a structured treatment milieu are also required. The intensity of service must necessitate close medical supervision by an eligible attending physician: psychiatrist for psychiatric or chemical dependency or an addictionologist for chemical dependency only. Intensity of service must also include a multi-modal, inter-disciplinary treatment program. The goal of acute inpatient care is to stabilize recipients who display acute conditions or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Active family/significant other involvement in therapy is expected unless contraindicated. Psychiatric or chemical dependency admissions may be emergencies or non-emergencies.
- b. Emergency is defined as, “the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others.”

In order for a psychiatric or chemical dependency admission to be considered emergent, one or more of the following criteria must be met:

1. violent, combative behavior at admission or risk of same (verbal threats, threatening nonverbal behavior, etc.);
 2. psychotic thought processes with inability to participate in the admissions process and with threat of elopement;
 3. serious suicide attempt or acutely suicidal with plan/means/access;
 4. acutely homicidal with plan/means/access; **OR**
 5. imminent physical danger with need for immediate detoxification (for chemical dependency ONLY)
- c. Discharge planning shall begin upon admission. Specific interventions to foster reintegration into home and community, or to identify and arrange for other placement and/or follow-up treatment may be included – e.g., partial hospitalization, intensive outpatient programming, further outpatient treatment, etc.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

Note: Most children will be able to get all the services they need under the core (basic) plan of NC Health Choice. A child who qualifies as having special needs may be able to receive additional services not covered by the core plan.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

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

3.2 Specific Criteria

- a. All benefits for inpatient psychiatric or inpatient chemical dependency hospitalization are subject to case management requirements.
- b. Psychiatric certification decisions are made by DMA's vendor according to medical necessity criteria and clinical protocols.
- c. Psychiatric inpatient hospital services are covered when:
 1. provided in a licensed psychiatric bed, and
 2. authorized by DMA's vendor.
- d. Chemical dependency inpatient hospital services are covered when:
 1. provided in a licensed substance abuse bed;
 2. authorized by DMA's vendor; and
 3. consistent with the criteria in a., the most current edition of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders.
- e. Professional fees for services by the attending psychiatrist or co-admitting psychologist are covered during any certified period when psychiatric services are provided and claims submitted on separate days.
- f. Professional fees for services by the attending psychiatrist or eligible co-admitting psychologist or attending addictionologist are covered during any certified period when chemical dependency services are provided and claims submitted on separate days.

- g. Failure to comply with the approval process may result in ineligibility for reimbursement.

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

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

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

4.2 Specific Criteria

Inpatient care is not covered in the following situations:

- a. Inpatient care for conditions not classified as psychiatric, emotional, or substance abuse illnesses.
- b. Inpatient psychiatric care rendered in a hospital not accredited by JCAHO.
- c. Inpatient chemical dependency care rendered in a facility which is not accredited by a nationally recognized accreditation organization approved by the state-wide vendor.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. For emergency inpatient admissions, requests for certification by DMA's vendor must be made within two business days of an emergency inpatient admission. Refer to **Subsection 1.0.b**. DMA's vendor is accessible 24-hours a day 7 days a week, 365 days per year, to accommodate requests for certification of emergency admissions.
- b. Prior approval by DMA's vendor is required prior to initiating non-emergency treatment, for continued treatment stays, and for the following services if utilized during the inpatient stay:
 - 1. Biofeedback
 - 2. Electroconvulsive therapy
 - 3. Hypnotherapy
 - 4. Psychological testing
- c. DMA's vendor will conduct a clinical review with the treating provider(s) to determine the medical necessity in response to the treating provider's request for the inpatient admission. Subsequent requests for authorization must be received prior to the expiration of any certified period, to determine the medical necessity for continued stay.

- d. The rationale for any admission must support medical necessity criteria for inpatient level of care and must be reflected in the data which documents the attending physician's rationale for admission.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Hospitals classified and accredited as psychiatric hospitals by the Joint Commission on Accreditation of Healthcare Organizations will be deemed to be hospitals for the purpose of the NC Health Choice Program.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

Claim Type

Institutional (UB-04/837I transaction)

A. Diagnosis Codes

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

B. Procedure Code(s)

074	0100	0101	0113	0114
0118	0123	0124	0133	0134
0143	0153	0154	0128	0138
0148	0158			

C. Modifiers

Providers are required to follow applicable modifier guidelines.

D. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

E. Place of Service

Inpatient Hospital

F. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

G. Reimbursement

Providers must bill their usual and customary charges.

Psychologists, addictionologists or other behavioral health practitioners may at times need to see a patient who has been hospitalized under the care of an admitting psychiatrist. When it is necessary for the outpatient provider to see an inpatient to facilitate treatment or facilitate transition back to the outpatient setting, that provider may be reimbursed when prior authorization is obtained from DMA's vendor.