Addictive and Mental Disorders Division

Medicaid Services Provider Manual for

Adult Mental Health and Substance Use Disorder

Effective April 1, 2018

Introduction

Purpose

The Addictive and Mental Disorders Division (AMDD) Medicaid Services Provider Manual (Manual) provides information pertaining to mental health and substance use disorder (SUD) services available to Medicaid members.

A provider must verify the individual is a Medicaid member. Medicaid eligibility can be verified at: https://mtaccesstohealth.portal.conduent.com/mt/general/home.do

For information about how to submit claims, please refer to: http://medicaidprovider.mt.gov/ or Provider Relations at: 1.800.624.3958 or (406) 442.1837.

Confidentiality

It is the policy of the Department of Public Health and Human Services (DPHHS) to comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). Information is exchanged in accordance with all applicable federal and state laws and regulations, as well as with the ethical and professional standards of the professions involved. These confidentiality policies govern all forms of information, including written records, electronic records, facsimile mail, and electronic mail. For more information pertaining DPHHS' HIPPA policy, please see: https://dphhs.mt.gov/HIPAA.

Definitions

For the purpose of the Manual, the following definitions apply:

(1) "American Society of Addiction Medicine (The ASAM Criteria)" means the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of individuals with addiction and co-occurring conditions.

(2) "Authorized Representative" means as defined in Administrative Rules of Montana (ARM) 37.5.304(2).

(3) "Code of Federal Regulations (CFR)" means the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government produced by the Office of the Federal Register (OFR) and the Government Publishing Office.

(4) "Crisis stabilization" means development and implementation of a short-term intervention to respond to a crisis, for the purposes of reducing the severity of a member's behavioral health symptoms and attempting to prevent admission of the member to a more restrictive environment.

(5) "Utilization Review Contractor (UR Contractor)" means the entity under contract with AMDD to complete agreed upon utilization review activities for Montana Medicaid Services.

(6) "Member" means an individual enrolled in the Montana Medicaid Program under 53-6-131, MCA, or receiving Medicaid-funded services under 53-6-1304, MCA.

(7) "Mental Health Center (MHC)" means a facility providing services for the prevention or diagnosis of mental health issues, the care and treatment of mental health issues, the rehabilitation of members with mental health issues, or any combination of these services. Information pertaining to becoming a licensed MHC is located at: http://dphhs.mt.gov/qad/Licensure.

(8) "State-approved program" means a program reviewed and accepted by the department to provide substance use disorder services.

Member Leaving a Correction Facility

Medicaid eligibility information for a member with justice involvement is available on: http://covermt.org/incarceration/

A member who is court ordered into services must still meet the requirements for prior authorization and medical necessity criteria for Montana Medicaid reimbursement. If a member is determined to be Medicaid eligible after admission, the member must also meet clinical management guidelines for Montana Medicaid reimbursement. Once a member is Medicaid eligible, the provider must complete a request for a prior authorization, if necessary. If at any time during the placement, a member no longer meets clinical guidelines OR is ineligible for Medicaid, the Department of Corrections becomes financially responsible for the cost of the placement for member committed to the Department of Corrections.

Section 1 Utilization Management

Unless otherwise specified, the following authorization process must be used to request prior authorizations and continued stay reviews. To determine if a service requires a prior authorization and/or a continued stay review, please see the At-a-Glance and specific service sections of this Manual. Current forms required for utilization management are available on the AMDD website at: http://dphhs.mt.gov/amdd/FormsApplications. The forms for each service includes the information regarding where and how to submit the form for the specific service.

Requesting a Prior Authorization

(1) The department or the UR Contractor may issue the prior authorization for as many days as deemed medically necessary up to the maximum number of days allowed as stated for each service requiring authorization. Authorization for less than the maximum days does not constitute a partial denial of services.
(2) The department or the UR Contractor must receive the complete request for a prior authorization no earlier than five business days prior to the admission of the member. Requests received earlier than five days prior the admission of the member will be technically denied. If a request is received after the member has been admitted, the request will be considered from the date the request was received by the department or the UR Contractor.
(3) The clinical reviewer will complete the prior authorization review process within three business days of receipt of complete information and take one of the following actions:
(a) request additional information as needed to complete the review; the provider must submit the requested information within five business days of the request for additional information;
(b) approve the prior authorization, as medically necessary up to maximum number of days allowed as stated for each service requiring authorization, and generate notification to all appropriate parties if the request meets the medical necessity criteria; or
(c) defer the case to a board-certified physician for review and determination if the prior authorization request does not appear to meet the medical necessity criteria.

(5) The board-certified physician will complete the review and determination within three business days of receipt of the information from the clinical reviewer.
(6) After a denial, a new prior authorization request may be submitted only if there is new clinical information.

Requesting a Continued Stay Review

(1) The department may issue the continued stay for up to the maximum number of days allowed as stated for each service requiring authorization. A provider may request a continued stay prior to the end of the initial stay authorization timeframe.
(2) The department must receive the request for continued stay no earlier than five business days prior to the end of the current authorized period. Requests received earlier than five days prior to the end of the current authorization will be technically denied. If a request is received after the authorized period has expired, the request will be considered from the date received by the department. The department will not retroactively authorize days if a continued stay request is received late.
(3) The following information must be submitted to the department for each continued stay review:
(a) changes to current DSM/ICD-10 diagnosis;
(b) justification for continued services at this level of care;
(c) a description of mental health and/or substance use disorder interventions and critical incidents;
(d) a copy of the member's most recent individualized treatment plan (ITP);
(e) a list of current medications and rationale for medication changes, if applicable; and
(f) a projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan.
(4) The clinical reviewer will complete the continued stay review process within three business days of receipt of complete information as described above and take one of the following actions:
(a) request additional information as needed to complete the review, the provider must submit the requested information within five business days of the request for additional information;
(b) authorize the continued stay as medically necessary for up to the maximum number of days allowed as stated for each service requiring authorization and generate notification to all appropriate parties if the continued stay meets the medical necessity criteria; or
(c) defer the case to a board-certified physician for review and determination if the continued stay does not meet the medical necessity criteria.
(5) The board-certified physician will complete the review and determination within four business days of receipt of the information from the clinical reviewer.
(6) After a denial, a new continued stay request may be submitted only if there is new clinical information.

Determinations

Upon completion of either the prior authorization or the continued stay review, one of the determinations below will be applied.

Authorization
An authorization determination indicates that the utilization review resulted in approval of all provider requested services or services units. A determination of approval does not guarantee payment, the member must also be determined eligible for the benefit. Payment is subject to the eligibility, applicable benefit provisions, and all other claim processing requirements at the time the service was rendered. All services are subject to retrospective review for appropriateness by the department or the UR Contractor.

Pending Authorization
A pending authorization indicates the clinical reviewer or physician has requested additional information from the provider.

Denial
When a request for authorization of payment does not meet the applicable criteria to justify Medicaid payment for the service requested, the request will be denied. Adverse determinations may be appealed according to the reconsideration review process and/or administrative review/fair hearing. A physician is the only party qualified who may issue a denial. A denial may be issued with additional days authorized for payment, specifically, denying a prior authorization request with "*approval for less than requested days*" for specific clinical reasons.

Technical Denial
When an adverse determination is based on procedural issues and not on medical necessity criteria, the result will be a technical denial. Technical denials can be overturned by AMDD only for the following reasons:
(1) There was a clinical reason why the request for prior authorization or continued authorization could not be made at the required time and the provider submitted a subsequent authorization request within five business days; or
(2) A timely request for prior authorization or continued authorization was not possible because of an equipment failure or malfunction of the department or the UR contractor that prevented the transmittal of the request at the required time and the provider submitted a subsequent authorization request within five business days.

If a technical denial is issued for submission of information outside the allowable timeframes, a provider may submit a new prior authorization request to the department or the UR Contractor. Requesting a new prior authorization after a technical denial does not waive the right to request an administrative review/fair hearing of the technical denial. A new prior authorization request may not be back dated and must provide sufficient clinical information to support an authorization.

Reconsideration Review Process
A reconsideration review provides the member/legal representatives, authorized representative, or the provider an opportunity for further clinical review if they believe there has been an adverse action regarding a denial determination.

There are two types of reconsideration reviews:

Peer-to-Peer: A Peer-to-Peer Review is a telephonic review between an advocating clinician, chosen by either the member/legal representative or the authorized representative, and the physician reviewer who rendered the adverse determination.

(1) The Peer-to-Peer Review is based upon the original clinical documentation and may consider clarification or updates.
(2) The Peer-to-Peer Review must be:
    (a) requested within ten business days of the adverse determination date; and
    (b) scheduled by the physician reviewer within five business days of the request.

Desk Review: A Desk Review may be requested in lieu of a Peer-to-Peer review or to provide a second opinion if the Peer-to-Peer Review results in an adverse determination. A Desk Review must be provided by a licensed psychiatrist who did not issue the initial or the Peer-to-Peer determination.

(1) The Desk Review is based upon the original clinical documentation and any additional supporting documentation.
(2) The Desk Review must be:
    (a) requested within 15 days of the most recent adverse determination date; and
    (b) performed by the physician within five business days of the written request and supporting documentation.

The legal representative, authorized representative, or provider must submit a written request to the department or the UR Contractor for this reconsideration review that states which review is being requested and naming an advocating physician. Further instructions pertaining to how to request a review are in the determination letter sent by the department or the UR Contractor. At any time during this review process a new prior authorization request may be submitted to provide additional clinical information and to begin an updated request for determination. If new clinical information becomes available after a denial of a reconsideration review for services, a provider may submit a new prior authorization to the UR Contractor based on the new clinical information.

Utilization Review, At-A-Glance

Below is a table that provides an At-A-Glance overview for utilization management of the adult mental health and substance use disorder services. For further utilization management details pertaining to each service, see Section 1.

Service	Prior Authorization	Continued Stay Review	Limits
Acute Inpatient Hospital Services	Required for Out of State (OOS) facilities - up to 60 days	Required for OOS facilities - up to 60 days	N/A
Acute PHP	Not Required	The provider must document in the file of the member every 90 days how	N/A

		the member meets the continued stay criteria	
ICBR	Required - up to 180 days	Required - up to 180 days	N/A
PACT	Required - up to 180 days	Required - up to 180 days	N/A
Secure Crisis Diversion	Not Required	Required for more than five days	N/A
TGH	Required - up to 120 days	Required - up to 90 days	N/A
TFC	Not Required	Not Required	N/A
Day TX	Not Required	Not Required	3 hours per day
DBT	Not Required	Not Required	N/A
Mental Health OP therapy (Individual and Group)	Not required for first 12 sessions (Individual and Group) per state fiscal year (SFY)	Member must meet SDMI criteria for more than 12 sessions (Individual and Group) per SFY	N/A
CBPRS	Not Required	Not Required	2 hours per day - Individual 2 hours per day - Group
IMR	Not Required	Not Required	N/A
MH and SUD TCM	Not Required for the first 96 units of service per member per SFY	Required for service greater than 96 units of service per member per SFY	N/A
SUD Medically Monitored Intensive Inpatient (ASAM 3.7)	Required - up to five days	Required - up to five days	N/A
SUD Clinically Managed High-Intensity Residential (ASAM 3.5)	Required - up to 21 days	Required - up to five days	N/A
SUD Clinically Managed Low-Intensity Residential (ASAM 3.1)	Required - up to 90 days	Required - up to 30 days	N/A
SUD Partial Hospitalization (ASAM 2.5)	Not Required	Not Required	N/A
SUD OP therapy (Individual and Group)	Not required for first 12 sessions (Individual and Group) per SFY	Member must meet High-Risk SUD criteria for greater than 12 sessions per SFY	N/A
SUD Biopsychosocial assessment	Not Required	Not Required	N/A
SUD Screening, Brief intervention, and Referral to Treatment	Not Required	Not Required	N/A

SUD Drug Testing	Not Required	Not Required	N/A

Administrative Review/Fair Hearing

Claims Denial Administrative Reviews

Prior to requesting an administrative review for denied claims, the provider must exhaust all administrative remedies available.

(1) For denied claims, those remedies may include:
   (a) researching the denial codes;
   (b) correcting errors and omissions; and
   (c) resubmitting the claims.

Assistance for providers with claims problems is available through the state's fiscal agent's provider relations program by calling (800) 624-3858 (in/out of state), (406) 442-1837 (Helena). If the fiscal agent is unable to assist the provider, the AMDD Program Officer responsible for the service affected may be contacted.

Administrative Review/Fair Hearing Process

Complete information about administrative reviews and fair hearings is found in administrative rule at Title 37, Chapter 5.

Section 2 Medicaid Mental Health

Coordination of Services Provided Concurrently

Services must not be provided to a member at the same time as another service if the service is the same in nature and scope regardless of funding source, including federal, state, local, and private entities. See the Concurrent Services Table in this Manual for Medicaid mental health services that may not be provided concurrently.

(1) All providers should be mindful of all community based services, regardless of funding source, that are potentially duplicative including those which are not in the AMDD's array of services. To avoid duplication, community based services that are provided concurrently require coordination. Community based services are those services which provide a member the opportunity to be served in their own home or community.
(2) Providers must demonstrate and document attempts made for coordination of community based services by:
   (a) informing a member or legal representative at intake of Medicaid's requirement for coordination of community based services and document other services a member is receiving (i.e. asking the member or legal representative if they are receiving other mental health related services and asking follow-up questions to determine which services they may be receiving);
   (b) obtaining a Release of Information (ROI) from a member or legal representative for all providers identified by a member or legal representative;

(c) contacting the providers, as indicated by a member or legal representative, to initiate coordination;

(d) maintaining a copy of one single coordinated ITP in each of the provider's member files (preferred) or maintaining copies of all ITPs in effect to illustrate the lack of duplication; and

(e) documenting each attempt to make reasonable efforts to coordinate treatment planning.

(3) The provider(s) must identify the role of each service or provider identified in the ITP(s). The ITP must clearly state which provider is accountable for the identified goal(s) or objective(s).

(4) A provider must furnish a copy of the member's ITP to a member or legal representative.

(5) If a member is receiving TCM associated with their mental health or substance use disorder, the TCM must coordinate the efforts in (1).

(6) The department is entitled to recover any payment a provider is not entitled to pursuant to ARM 37.85.406.

Mental Health Severe Disabling Mental Illness (SDMI)

The following SDMI clinical guidelines must be employed for each covered Medicaid mental health service, unless otherwise indicated. A licensed mental health professional must certify the member continues to meet the criteria for having a SDMI annually. The clinical assessment must document how the member meets the criteria for having a SDMI.

SDMI Definition

SDMI is defined as an adult, 18 years or older, who presently or any time in the past 12 months has had a diagnosable mental illness, as described below, that has interfered with the member's functioning, and has resulted in significant difficulty in community living without supportive treatment or services of a long-term or indefinite duration. A SDMI is chronic and persistent resulting in impaired functioning.

(1) A member who meets the criteria in (a) and (b) is SDMI eligible, the provider does not need to compete the Level of Impairment (LOI) worksheet:

(a) the member has been involuntarily hospitalized for at least 30 consecutive days, because of a mental disorder, at Montana State Hospital (MSH) within the past 12 months; or

(b) has a diagnosis within the following Schizophrenia Spectrum Disorder category:

Schizophrenia Spectrum

- Schizophrenia, paranoid type, F20.0
- Schizophrenia, disorganized type, F20.1
- Schizophrenia, catatonic type, F20.2
- Schizophrenia, residual type, F20.5
- Delusional disorder, F22
- Schizoaffective disorder, bi-polar Type, F25.0
- Schizoaffective disorder, depressive type, F25.1

(2) If the member does not meet the criteria listed in (1)(a) or (1)(b), the provider must complete the SDMI Eligibility Form and the LOI Worksheet to determine if the member meets the diagnostic and LOI criteria for the SDMI designation. The forms are located at:

http://dphhs.mt.gov/amdd/FormsApplications. The provider must complete the SDMI Eligibility Form and the LOI Worksheet annually and must keep them in the file/chart of the member. AMDD reserves the right to audit the SDMI eligibility forms of all mental health providers using the SDMI designation. The following are SDMI covered diagnoses:

CATEGORY 1

- **Bipolar 1 and Related Disorders**
  - Bipolar I disorder, manic w/out psychotic features, moderate, F31.12
  - Bipolar I disorder, manic w/out psychotic features, severe, F31.13
  - Bipolar I disorder, manic, severe with psychotic features, F31.2
  - Bipolar I disorder, depressed, moderate, F31.32
  - Bipolar I disorder, depressed, severe, w/out psychotic features, F31.4
  - Bipolar I disorder, depressed, severe, with psychotic features, F31.5
  - Bipolar I disorder, mixed, moderate, F31.62
  - Bipolar I disorder, mixed, severe, w/out psychotic features, F31.63
  - Bipolar I disorder, mixed, severe, with psychotic features, F31.64
  - Bipolar II disorder, F31.81
- **Depressive Disorder**
  - Major depressive disorder, severe w/out psychotic features, F32.2
  - Major depressive disorder, severe with psychotic features, F32.3
  - Major depressive disorder, recurrent, severe w/out psychotic features, F33.2
  - Major depressive disorder, recurrent, severe, with psychotic features, F33.3
- **Posttraumatic Stress Disorders (PSTD)**
  - Post-traumatic stress disorder, acute, F43.11
  - Post-traumatic stress disorder, chronic, F43.12
- **Personality Disorders**
  - Borderline personality disorders, F60.3
- **Neurodevelopmental Disorders**
  - Autistic disorder, F84.0

CATEGORY 2

- **Depressive Disorders**
  - Major depressive disorder, moderate, F32.1
  - Major depressive disorder, recurrent, moderate, F33.1
- **Dissociative Disorders**
  - Dissociative amnesia, F44.0
  - Dissociative fugues, F44.1
  - Dissociative stupor, F44.2
  - Dissociative identity disorder, F44.81
- **Panic Disorders**
  - Panic disorder with agoraphobia, F40.01
  - Panic disorder without agoraphobia, F41.0
- **Generalized anxiety disorder, F41.1**
- **Obsessive Compulsive and Related Disorders (OCD)**

    - Obsessive compulsive disorder, F42.2
- **Persistent depressive disorder (dysthymia), F34.1**
- **Feeding and Eating Disorders**
    - Anorexia nervosa, restricting type, F50.01
    - Anorexia nervosa, binge eating/purging type, F50.02
    - Bulimia nervosa, F50.2
- **Gender Dysphoria**
    - Gender dysphoria, F64.1

Section 3 Medicaid Mental Health Services

Acute Inpatient Hospital Services

Definition:

(1) Inpatient hospital services means services that are ordinarily furnished in an acute care hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other practitioner as permitted by federal law, and are furnished in an institution that:
   (a) is licensed or formally approved as an acute care hospital by the officially designated authority in the state where the institution is located;
   (b) except as otherwise permitted by federal law, meets the requirements for participation in Medicare as a hospital and has in effect a utilization review plan that meets the requirements of 42 CFR 482.30; or
   (c) provides acute care psychiatric hospital services as defined in this manual for members under age 21.

Provider Requirements:

Inpatient hospital services are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients. Services must be provided under the direction of a licensed physician in a facility maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental illness. The facility must be currently licensed by the designated state licensing authority in the state where the facility is located and must meet the requirements for participation in Medicaid as a hospital.

Medical Necessity Criteria:

(1) A current DSM diagnosis as the primary diagnosis; and
(2) The member is a danger to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

Prior Authorization:

(1) A certificate of need is not required for members 21 years of age and older, the requirements at 42 CFR 456.60 are met by having the physician admit the member.
(2) For members ages 18 to 21 years, a certificate of need is required pursuant to 42 CFR 441.152 and 441.153, in addition to the medical necessity documentation. For emergency admissions, the certificate of need must be made by the team responsible for the plan of care within 14 days after admission.
(3) Prior authorization is not required for in-state acute inpatient hospital. Prior authorization is required for OOS facilities and must be submitted to the department or the UR Contractor within one business day of admission to the facility.
(4) The department or the UR Contractor may issue the prior authorization for as many days as deemed medically necessary up to 60 days.

Service Requirements:
Acute inpatient hospital services must be provided in accordance with all state and federal regulations pertaining to the administration of the service.

Continued Stay Review:
For OOS facilities, the department or the UR Contractor may issue the continued stay authorization for as many days as deemed medically necessary.

Continued Stay Criteria:
(1) DSM diagnosis as the primary diagnosis;
(2) Active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria and that still exist;
(3) A lower level of care is inadequate to meet the member's needs regarding either treatment or safety; and
(4) There is reasonable likelihood of clinically significant benefit because of the medical intervention requiring the inpatient setting or a high likelihood of either risk to the member's safety or clinical well-being or of further significant acute deterioration in the member's condition without continued care in the inpatient setting, with lower levels of care inadequate to meet these needs.

Billing Requirements:
All claims for inpatient hospital services provided to Medicaid members must be submitted on a UB-04 form.

UR Required Forms:
Certificate of need (18-21 years of age)
Prior authorization
Continued stay review request

Acute Partial Hospital Program (PHP)

Definition:
Acute PHP means a time limited active treatment program that offers therapeutically intensive, coordinated, structured clinical services. Acute PHP may include day, evening, night, and weekend treatment programs that must employ an integrated, comprehensive, and complementary schedule of recognized treatment or therapeutic activities.

Provider Requirements:
Acute PHP is provided by programs that are operated by a hospital with a distinct psychiatric unit and are co-located with that hospital such that, in an emergency, a member of the Acute PHP can be transported to the hospital's inpatient psychiatric unit within 15 minutes.

Medical Necessity Criteria:
(1) The member must meet the SDMI criteria as described in this Manual and:
   (a) the member is experiencing psychiatric symptoms of sufficient severity to create severe impairments in educational, social, vocational, or interpersonal functioning;
   (b) the member cannot be safely and appropriately treated in a less restrictive level of care;
   (c) proper treatment of the member's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician; and
   (d) the services can reasonably be expected to improve the member's condition or prevent further regression.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Acute PHP must be provided in accordance with all applicable state and federal regulations and the provider must meet the following requirements:
   (a) document how the member meets the medical necessity criteria, in the file of the member, within one business day of admission;
   (b) complete a clinical assessment within 10 business days of admission;
   (c) provide a face-to-face evaluation completed by a physician;
   (d) initiate active discharge planning at the time of admission to the program and culminate into a comprehensive discharge plan;
   (e) develop and implement a comprehensive ITP that is updated every 30 days, or as needed, to reflect progress of the member;
   (f) provide crisis intervention and management, including response outside of the program setting; and
   (g) provide psychiatric evaluation, consultation, and medication management as appropriate to the needs of the member.

Continued Stay Review:
The provider must document, every 90 days, how the member meets the continued stay criteria in the file of the member.

Continued Stay Criteria:

(1) The member continues to meet ALL admission criteria and the following:
   (a) active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the member to receive services in a less intensive outpatient setting; and
   (b) demonstrated and documented progress is being made toward the treatment goals and there is a reasonable likelihood of continued progress

Billing Requirements:
Claims must be submitted on a UB-04 form. Partial hospitalization services must be billed under Revenue Code 912 and must include a Montana-specific procedure code in the HCPCS field (Form Locator 44) on the UB-04 form. For partial hospitalization services, use Code H0035 with the appropriate modifier.

UR Required Forms:
Not Applicable

Intensive Community-Based Rehabilitation (ICBR)

Definition:
ICBR services are provided in a group home setting and provide rehabilitation services to members who have a history of institutional placements and a history of repeated unsuccessful placements in less intensive community-based programs. The purpose of the service is to reduce disability and restore the best possible functional level. ICBR includes the following service components:

- medication administration and monitoring;
- community reintegration; and
- independent living.

Provider Requirements:
ICBR may be provided by a licensed MHC. A provider must be under contract with the department to provide this service and be knowledgeable about commitment and recommitment processes, as well as the process for use of involuntary medications. Pursuant to 53-21-127(6), MCA, any involuntary medication ordered through the commitment process must be reviewed by a “medication review committee”.

Medical Necessity Criteria:
(1) Only MSH or the Montana Mental Health Nursing Care Center (MMHNCC) may refer the member to ICBR services.
(2) The member must meet the SDMI criteria as described in this Manual and the member:
   (a) be in the MSH or the MMHNCC and is ready for discharge;
   (b) requires a structured treatment environment to be successfully treated in a less restrictive setting;
   (c) has a history of institutional placement, at least one full year of institutional care in the past three years, as well as a history of repeated unsuccessful placements in less intensive community-based programs;

(d) exhibits an inability to perform daily living activities in an appropriate manner because of the SDMI; and
(e) presents with SDMI symptoms of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health services.

Prior Authorization:
Prior authorization is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 180 days.

Service Requirements:
(1) A physician or mid-level practitioner must be available for management of psychiatric medications.
(2) ICBR services must include:
(a) crisis stabilization services as needed by ICBR members;
(b) close supervision and support of daily living activities;
(c) assistance with medications, including administration of medications as necessary;
(d) rehabilitation in areas of community reintegration and independent living;
(e) care coordination;
(f) discharge planning for transition to a less restrictive setting; and
(g) transportation to appropriate community resources.
(3) The provider must submit a quarterly report to the department which includes:
(a) quarterly enrollment;
(b) length of stay;
(c) progress report;
(d) a summary of services provided each member; and
(e) a discharge summary which includes where the member was discharged to.

Continued Stay Review:
Continued stay reviews are required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 180 days.

Continued Stay Criteria:
(1) The member continues to exhibit behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH, MMHNCC, or acute inpatient care if services are not provided to be successfully treated in a less restrictive setting AND the following:
(a) active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the member to receive services in a less intensive outpatient setting;
(b) demonstrated and documented progress is being made toward the treatment goals and there is a reasonable likelihood of continued progress; and
(c) ICBR is the least restrictive service to meet the clinical needs of the member.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's Resource-Based Relative Value Scale (RBRVS) fee schedule, adjusted for the provider type.

Required UR Forms:
Prior authorization
Continued stay review request

Program of Assertive Community Treatment (PACT)

Definition:
PACT is a member-centered, recovery oriented, mental health services delivery model for facilitating community living, psychosocial rehabilitation, and recovery for members who have not benefited from traditional outpatient services. PACT is a multi-disciplinary, self-contained clinical team approach, providing long-term intensive care and all mental health services in natural community settings. Interventions focus on achieving maximum reduction of physical and mental disability and restoration of the member to their best possible functional level. PACT is 24 hours a day, 7 days a week, 365 days a year service in all settings except jails, detention centers, clinic settings, and inpatient hospital settings. PACT includes the following components:

- psychiatric/medical assessment/evaluation;
- medication administration, management, and monitoring;
- individual, group, and family therapy;
- community psychiatric supportive treatment;
- CBPRS;
- co-occurring substance abuse treatment;
- peer support; and
- vocational rehabilitation.

Provider Requirements:
PACT may be provided by a licensed MHC. PACT teams must be approved by the department. For department approval the provider must submit the following request:
(1) PACT Program Implementation and Annual Plan.
(2) Montana PACT Program Staffing Requirements Roster.

Medical Necessity Criteria:

Member must meet the SDMI criteria as described in this manual and two or more of the following criteria that are indicators of continuous, greater than eight hours per month, high-service needs:

(1) The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates the following due to the SDMI:
   (a) significantly impaired interpersonal or social functioning;
   (b) significantly impaired occupational functioning;
   (c) impaired judgment;
   (d) poor impulse control; or
   (e) lack of family or other community or social supports.
(2) Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community or persistent or recurrent failure to perform daily living tasks without significant support or assistance from others.
(3) Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
(4) Inability to maintain a safe living situation.
(5) 2 or more admissions per year into acute psychiatric hospitals, crisis stabilization facilities, or psychiatric emergency services.
(6) Intractable (persistent or very recurrent) or severe major symptoms which present with affective, psychotic, or at risk for harm to self or others.
(7) Coexisting SUD with a duration of greater than six months.
(8) High risk or recent history of criminal justice involvement.
(9) Inability to meet basic survival needs or residing in sub-substandard housing, homeless, or at imminent risk of being homeless.
(10) Residing in an inpatient bed or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
(11) Inability to participate in traditional outpatient services.

Prior Authorization:

Prior authorization is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 180 days.

Service Requirements:

(1) PACT teams must comply with the Montana PACT Standards. The department adopts and incorporates by reference the Montana PACT Standards (2011) which set forth the standards of treatment for PACT. A copy of the standards may be obtained from the: AMDD, P.O. Box 202905, Helena, MT 59620-2905 or the following web site: http://www.dphhs.mt.gov/amdd/services/index.shtml.
(2) A provider must submit the following to the department when a member is admitted or discharges from services:
   (a) notification of PACT Admission; or
   (b) notification of PACT Discharge.

Continued Stay Review:

Continued stay reviews are required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 90 days.

Continued Stay Criteria:
Continued stay requests will be considered only when the member continues to meet the SDMI criteria and all the following:

(1) The prognosis for treatment of the SDMI at a less restrictive level of care remains poor because the member still demonstrates two or more of the following:
   (a) significantly impaired interpersonal or social functioning;
   (b) significantly impaired educational or occupational functioning;
   (c) impairment of judgment; or
   (d) poor impulse control.
(2) As a result of the SDMI, the member exhibits an inability to perform daily living activities in a developmentally appropriate manner without the structure of the PACT service.
(3) The SDMI symptoms of the member are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by other outpatient or in-home mental health services.
(4) The member continues to require at least three of the following services:
   (a) medication management;
   (b) psychotherapy;
   (c) community psychiatric supportive treatment;
   (d) skills training;
   (e) vocational services; or
   (f) co-occurring services.
(5) The member has demonstrated progress toward identified treatment goals and has a reasonable likelihood of continued progress.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Prior authorization
Continued stay review request

Secure Crisis Diversion, a/k/a Crisis Intervention Facility

Definition:
Secure Crisis Diversion is short-term emergency, 24-hour care, treatment, and supervision for crisis intervention and stabilization. It is a residential alternative of fewer than 16 beds to divert from inpatient hospitalization. The service includes medically monitored residential services to provide psychiatric stabilization on a short-term basis. The service reduces disability and

restores members to previous functional levels by promptly intervening and stabilizing when crisis situations occur. The focus is on goals for recovery, preventing continued exacerbation of symptoms, and decreasing risk of need for hospitalization or higher levels of care. Secure Crisis Diversion includes the following:

- observation of symptoms and behaviors;
- support or training for self-management of psychiatric symptoms;
- close supervision;
- psychotropic medications administered during the crisis stabilization period; and
- monitoring behavior after the administration of medication.

Provider Requirements:
Secure Crisis Diversion may be provided by a licensed MHC. Secure Crisis Diversion providers must be approved by the department.

Medical Necessity Criteria:
The member must have a current mental health diagnosis from the DSM, moderate or severe, as the primary diagnosis. The member poses a danger to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

Prior Authorization:
Prior authorization is not required. Admission to Secure Crisis Diversion requires documentation in the member's file of a current DSM diagnosis, as the primary diagnosis. The member is a danger to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

Service Requirements:
(1) Secure Crisis Diversion must include:
  (a) crisis stabilization services as needed;
  (b) 24-hour direct care staff;
  (c) assistance with medications including administration of medications as necessary; and
  (d) a 24-hour on-call mental health professional.

Continued Stay Review:
Continued stay reviews are required for services exceeding 5 days. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 5 days.

Continued Stay Criteria:
(1) A current DSM diagnosis, moderate or severe, as the primary diagnosis and all the following:
  (a) active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria; and
  (b) a lower level of care is inadequate to meet the member's treatment or safety needs.

(2) In addition to (1) above, either (a), (b), or (c) below:
   (a) there is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the inpatient setting;
   (b) there is a high likelihood of either risk to the member's safety, clinical well-being, or of further significant acute deterioration in the member's condition without continued care and lower levels of care inadequate to meet these needs; or
   (c) the appearance of new impairments meeting admission guidelines.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Continued stay review request

Therapeutic Group Home (TGH)

Definition:
TGH services provide a supported living environment in a licensed group home for members. The purpose of the service is to provide behavioral interventions to reduce disability, restore best possible functioning levels in one or more areas, and encourage recovery so the member can be successful in a home and community setting. TGH services includes the following components:

- individual, family, and group therapy;
- independent living and skills training; and
- community adjustment training in the home or community.

Provider Requirements:
TGH may be provided by a licensed MHC.

Medical Necessity Criteria:
Member must meet the SDMI criteria as described in this Manual and:
(1) The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates three or more of the following due to the SDMI:
   (a) significantly impaired interpersonal or social functioning;
   (b) significantly impaired occupational functioning;
   (c) impaired judgment;
   (d) poor impulse control; or
   (e) lack of family or other community or social supports.
(2) Due to the SDMI, the member exhibits an inability to perform daily living activities in an appropriate manner;

(3) The SDMI symptoms of the member are persistent in nature, requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service; and
(4) The member exhibits behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH or acute care if services are not provided, or the member is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment to be successfully treated in a less restrictive setting.

Prior Authorization:
Prior authorization is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 120 days.

Service Requirements:
(1) TGH must be provided in accordance with all applicable state and federal regulations and meet the following weekly therapeutic service requirements:
  (a) 30 minutes of psychotherapy; and
  (b) 2 hours of individual and/or group skills training.
(2) A provider may be reimbursed for reserving a bed for a member who is on a therapeutic home visit (THV) for up to 14 days per member per SFY. The purpose of the home visit must be to assess the ability of the member to successfully transition to a less restrictive level of care. The member's ITP must document the clinical need for a THV and the provider must clearly document staff contacts and member achievements or regressions during the THV.

Continued Stay Review:
Continued stay reviews are required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 90 days.

Continued Stay Criteria:
(1) The member continues to exhibit symptoms and behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH or acute inpatient care if services are not provided or to be successfully treated in a less restrictive setting AND the following:
  (a) active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the member to receive services in a less intensive outpatient setting;
  (b) demonstrated and documented progress is being made toward the treatment goals and there is a reasonable likelihood of continued progress; and
  (c) TGH is the least restrictive service to meet the clinical needs of the member.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:

Prior authorization
Continued stay review request

Adult Therapeutic Foster Care (TFC)

Definition:
Adult TFC services are in-home supervised support services in a licensed foster home. The purpose of the service is to provide behavioral interventions to reduce disability, restore previous functioning levels in one or more areas, and encourage recovery so the member can be successful in a home and community setting. Adult TFC includes the following components:

- clinical assessment;
- crisis services; and
- an adult foster care specialist.

Provider Requirements:
TFC may be provided by a licensed MHC.

Medical Necessity Criteria:
The member must meet the SDMI criteria as described in this Manual and all the following:

(1) The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates three or more of the following due to the SDMI:
   (a) significantly impaired interpersonal or social functioning;
   (b) significantly impaired occupational functioning;
   (c) impaired judgment;
   (d) poor impulse control; or
   (e) lack of family or other community or social supports.
(2) Resulting from the SDMI, the member exhibits an inability to perform daily living activities in an appropriate manner.
(3) The SDMI symptoms of the member are of a severe or persistent nature requiring more 1:1 intensive treatment and clinical supervision than can be provided by outpatient mental health services.
(4) The member exhibits behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH or acute care if services are not provided, or the member is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment to be successfully treated in a less restrictive setting.

Prior Authorization:
Prior authorization is not required. The provider must document in the file of the member that they meet the medical necessity criteria.

Service Requirements:
Adult TFC must be provided in accordance with all applicable state and federal regulations.
A provider may be reimbursed for reserving a bed for a member who is on a THV for up to 14 days per member per SFY. The purpose of the THV must be to assess the ability of the member

to successfully transition to a less restrictive level of care. The member's ITP must document the clinical need for a THV and the provider must clearly document staff contacts and member achievements or regressions during the THV.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

Day Treatment (Day TX)

Definition:
Day TX services are a set of mental health services for members whose mental health needs are severe enough that they display significant functional impairment. This service is a community-based alternative to more restrictive levels of care. Services are directed by a program supervisor and/or program therapist who is knowledgeable about the service and support needs of members with a mental illness, Day TX programming, and psychosocial rehabilitation. Day TX provides services at a ratio of no more than one to ten members. Services are focused on improving skills related to exhibiting appropriate behavior, independent living, crisis intervention, job skills, and socialization so the member can live and function more independently in the community. Day TX includes the following:

- CBPRS; and
- group therapy.

Provider Requirements:
Day TX may be provided by a licensed MHC.

Medical Necessity Criteria:
The member must meet the SDMI criteria as described in this Manual and all of the following:
(1) The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates three or more of the following due to the SDMI:
    (a) significantly impaired interpersonal or social functioning;
    (b) significantly impaired occupational functioning;

(c) impairment of judgment;
(d) poor impulse control; or
(e) lack of family or other community or social networks.

(2) Resulting from the SDMI, the member exhibits an inability to perform daily living activities in an appropriate manner.

(3) The SDMI symptoms of the member are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health services.

(4) The member exhibits behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH or acute care if services are not provided, or the member is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment to be successfully treated in a less restrictive setting.

(5) The member must have the capacity to engage in the structured settings of a rehabilitative and psychotherapeutic setting to engage in the skills and therapeutic activities of a Day TX program.

Prior Authorization:
Prior authorization is not required.

Service Requirements:

(1) Services may be provided no less than 2 and up to 3 hours per day for half-day Day TX services.

(2) Services must be based on a current comprehensive assessment and included as an intervention in the member's individualized ITP, which must:
(a) be reviewed and updated every 90 days; and
(b) document the interventions provided and the member's response.

(3) The following are not allowed as Day TX services:
(a) primarily recreation-oriented activities or activities provided in a setting that is not medically supervised;
(b) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the member's SDMI;
(c) prevention or educational programs provided in the community; and
(d) any times where the member leaves the program and is not participating in the program.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

Billing Requirements:

Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

Dialectical Behavioral Therapy (DBT)

Definition:
DBT is an evidence-based service that is a comprehensive, cognitive-behavioral treatment. DBT includes the following components:

- individual therapy
- group therapy; and
- skills development and training.

Provider Requirements:
DBT may be provided by a private licensed mental health professional, a licensed mental health professional associated with a MHC, or licensure candidates (under clinical supervision).

Medical Necessity Criteria:
The member must meet the SDMI criteria as described in this Manual and:

(1) The member must have ongoing difficulties in functioning because of the SDMI for a period of at least six months, or for an obviously predictable period over six months, as evidenced by all of the following:
   (a) dysregulation of emotion, cognition, behavior, and interpersonal relationships;
   (b) recurrent suicidal, parasuicidal, serious self-damaging impulsive behaviors, or serious danger to others;
   (c) a history of treatment at a higher level of care; and
   (d) evidence that lower levels of care are inadequate to meet the needs of the member.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Services must be based on a current comprehensive assessment and included as an intervention in the member's individualized ITP.
(2) DBT must be provided by a licensed mental health professional or a licensure candidate (under clinical supervision), who has at least 6 hours of classroom DBT training within the past 3 years, from a qualified DBT training program.
(3) The mental health professional or licensure candidate must:
   (a) identify, prioritize, sequence, and treat behavioral targets and goals;
   (b) assist the member to manage crisis and harmful behaviors; and

(c) assist the member with learning and applying effective behaviors when working with other treatment team supports/providers.

(4) Services may be provided in an individual and/or group setting.

(5) Individual DBT sessions must combine rehabilitative and psychotherapeutic interventions that emphasize problem-solving behavior for the past week's issues and problems, as well teaching and improving the skills taught in the group therapy sessions.

(6) Group DBT skills training sessions must teach the skills from the four following modules to decrease dysfunctional coping behaviors and restore positive functioning by teaching adaptive skills:
(a) interpersonal effectiveness,
(b) distress tolerance and reality acceptance skills,
(c) emotion regulation, and
(d) mindfulness.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Forms Required:
Not applicable.

Mental Health Outpatient (OP) Therapy (Individual and Group)

Definition:
Outpatient therapy services include individual and group therapy in which diagnosis, assessment, psychotherapy, and related services provided by a licensed mental health professional acting within the scope of the professional's license or a licensure candidate (under clinical supervision).

Provider Requirements:
OP therapy may be provided by a private licensed mental health professional, a licensed mental health professional associated with a MHC, or licensure candidates (under clinical supervision).

Medical Necessity Criteria:

For the first 12 sessions of individual and 12 sessions of group per SFY:

(1) The member must have a recognized mental health diagnosis from the most current edition of the DSM.

(2) Outpatient therapy services that do not count towards the first 12 sessions are as follows:
   (a) psychiatric diagnostic or evaluative interview procedures;
   (b) outpatient psychotherapy with medication evaluation and management services;
   (c) pharmacological or medication management services; and
   (d) central nervous system assessments/tests or psychological testing performed by a physician or psychologists.

Prior Authorization:

Prior authorization is not required.

Service Requirements:

(1) Group therapy services may not have more than eight members participating in the group.

(2) The provider must:
   (a) formulate an ITP on admission that identifies strength-based achievable goals and measurable objectives that are directed toward the alleviation of the symptoms and/or causes that led to the treatment;
   (b) document the response of the member to treatment and revise the ITP consistent with the clinical needs of the member; and
   (c) for sessions more than 12 individual and 12 group, formulate a discharge plan regularly review and revise. The discharge plan must identify specific target dates for achieving specific goals and define criteria for conclusion of treatment.

Continued Stay Review:

Not applicable.

Continued Stay Criteria:

For individual sessions more than 12 per SFY and group sessions more than 12 per SFY the provider must document in the file of the member the following:

(1) The member must meet the SDMI criteria as defined in this Manual and:
   (a) the member has demonstrated investment in the therapeutic alliance and has agreed to the goals/objectives of the ITP; and
   (b) progress toward treatment goals has occurred as evidenced by measurable reduction of symptoms or behaviors that indicate continued responsiveness to treatment.

Billing Requirements:

Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:

Not applicable.

Community Based Psychiatric Rehabilitation Support (CBPRS)

Definition:
CBPRS are one-to-one, face-to-face, intensive behavior management and stabilization services in home, workplace, or community settings, for a specified period, in which the problem or issue impeding recovery or full functioning is defined and treated. The purpose of CBPRS is to reduce disability and restore function. Through CBPRS, a behavioral aide supports the member by augmenting life, behavioral, and social skills training needed to reach their identified treatment goals and restore member functioning in the community. During skills training, the behavioral aide clearly describes the skill and expectations of the member's behavior, models the skill and engages the member in practice of the skill, and provides feedback on skill performance. Restoring these skills helps prevent relapse and strengthens goal attainment. These aides may consult face-to-face with family members or other key individuals that are part of a member's treatment team to determine how to help the member be more successful in meeting treatment goals.

Provider Requirements:
CBPRS may be provided by a licensed MHC.

Medical Necessity Criteria:
Member must meet the SDMI criteria as described in this Manual and is receiving other adult mental health services.

Prior Authorization:
A prior authorization is not required.

Service Requirements:
(1) CBPRS may be provided in an individual and/or group setting.
(2) Daily progress notes must include the time in and out for both individual and group services.
(3) Individual CBPRS may be provided up to maximum of 2 hours of group and 2 hours of individual in a 24-hour period.
(4) Group CBPRS may include up to 8 adults in the group per one staff.
(5) The ITP must include CBPRS rehabilitation goals that address the member's primary mental health needs.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

Billing Requirements:

Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

Illness Management and Recovery Services (IMR)

Definition:
IMR is an evidenced-based service program that teaches a broad set of individualized strategies for managing mental illness. IMR is designed to assist the member with reducing disability and restoring functioning by providing information about mental illness and coping skills to help them manage their illness, develop goals, and make informed decisions about their treatment. There is a strong emphasis on assisting members to set and pursue personal goals and converting strategy into action in their daily lives. The goals are reviewed on an ongoing basis by the provider, behavioral aide, and member.

Provider Requirements:
IMR may be provided by a private licensed mental health professional, a licensed mental health professional associated with a MHC, or licensure candidates (under clinical supervision). The practitioner providing IMR services must trained in IMR services.

Medical Necessity Criteria:
(1) Member must meet the SDMI criteria as described in this Manual; and
(2) The member has chosen IMR as his/her choice of treatment as indicated in the most current ITP.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) The following materials must be used in the provision of IMR:
    (a) IMR Practitioners Guide; and
    (b) IMR Educational Handouts.
(2) Services must be based on a current comprehensive assessment and included as an intervention in the member's ITP.
(3) The provider must provide a minimum of one weekly individual or group session.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Continued stay review is not required.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

Mental Health Targeted Case Management (TCM)

Definition:
TCM means as defined in the 42 CFR 440.169.

Provider Requirements:
TCM may be provided by a licensed MHC.

Medical Necessity Criteria:
(1) Member must meet the SDMI criteria as described in this Manual and:
   (a) the member/representative gives consent and agrees to participate in TCM;
   (b) the need for TCM must be documented by a mental health professional; and
   (c) the member is receiving other adult mental health or substance use disorder services.
(2) TCM services cannot be used for activities that are the responsibility of other systems.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
Services are to be delivered in accordance with 42 CFR 440.169, 42 CFR 441.18, and 42 CFR 431.51. For further detail, please see the most current version of the TCM Montana Medicaid provider notice at http://medicaidprovider.mt.gov/

Continued Stay Review:
A continued stay review is required for services more than 96 units per member per SFY. The department or the UR Contractor may issue the authorization for as many units as deemed medically necessary up to 24 units.

Continued Stay Criteria:
TCM is considered medically necessary when member has ALL of the following:
(1) The member continues to meet SDMI criteria;

(2) Documentation of members participation and engagement in TCM;
(3) The member is allowing coordination of care with other providers, is involving family members where indicated, and evidence of this is documented; and
(4) The member meets one of the following:
    (a) progress toward accessing needed services is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment and support services, improving severity of symptoms and functional impairment, and continued progress; or
    (b) if progress is not documented, member has been re-assessed, treatment needs have been re-evaluated, and with new linkage needs have been identified.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. MHCs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Continued stay review request.

Concurrent Services Guide

The services listed below may NOT be billed concurrently unless there is an exception listed.

Acute Inpatient Hospital
- All AMDD Services (Notes/Exceptions - TCM may be provided up to 180 consecutive days)

Acute PHP
- Acute Inpatient Hospital
- ICBR
- PACT
- Secure Crisis Diversion
- TGH
- Day Tx
- DBT
- OP therapy (Individual and Group)
- CBPRS (Notes/Exceptions - May not be provided during PHP program hours)
- IMR

ICBR
- Acute Inpatient Hospital
- PHP
- PACT

- Secure Crisis Diversions
- TGH
- TFC
- Day TX
- CBPRS
- TCM

PACT

- Acute Inpatient Hospital
- PHP
- ICBR
- Secure Crisis Diversions
- TGH
- TFC
- Day TX
- DBT
- OP therapy (Individual and Group)
- CBPRS
- IMR
- TCM

Secure Crisis Diversion

- Acute Inpatient Hospital
- PHP
- ICBR
- PACT
- TGH
- TFC
- Day TX

TGH

- Acute Inpatient Hospital
- PHP
- ICBR
- PACT
- Secure Crisis Diversion
- TFC
- Day TX
- DBT
- CBPRS
- IMR

TFC

- Acute Inpatient Hospital
- ICBR
- PACT
- Secure Crisis Diversion
- TGH

Day TX

- Acute Inpatient Hospital
- PHP
- ICBR
- PACT
- Secure Crisis Diversion
- IMR (Notes/Exceptions – May not be provided during Day TX hours)
- OP therapy (Individual and Group)
- CBPRS
- TCM (Notes/Exceptions – TCM may not be provided during Day TX hours)

DBT

- Acute Inpatient Hospital
- PHP
- PACT
- Secure Crisis Diversion

OP therapy (Individual and Group)

- Acute Inpatient Hospital
- PHP
- ICBR
- PACT
- Secure Crisis Diversion
- Day TX
- TFC
- IMR

IMR

- Acute Inpatient Hospital
- PHP
- ICBR
- PACT
- Secure Crisis Diversion
- Day TX (Notes/Exceptions – IMR may not be provided during Day TX hours)

- DBT
- OP therapy (Individual and Group)

CBPRS

- Acute Inpatient Hospital
- PHP (Notes/Exceptions – May not be provided during PHP program hours)
- ICBR
- PACT
- Secure Crisis Diversion
- TGH
- Day TX

TCM

- Acute Inpatient Hospital (Notes/Exceptions - TCM may be provided up to 180 consecutive days)
- ICBR
- PACT
- Secure Crisis Diversion
- Day TX (TCM may not be provided during Day TX hours)

Service Components

Medicaid mental health services referenced in Section 3 contain several components within each service. The components are defined below for clarity.

(1) "Adult foster care specialist" means a specialized service that includes the implementation, coordination, and management of mental health services provided to a member to promote rehabilitation and treatment activities to restore levels of independence. The adult foster care specialist provides a minimum of weekly contacts with the foster care parent and a member in the home to assess whether the supports and services are adequate to meet a member's needs. A program supervisor, who is experienced with working with members with a mental illness, will supervise the adult foster care specialist. Services can be provided by an individual with a bachelor's degree in a human services field with one year of full time mental health experience and/or a program supervisor.

(2) "Community adjustment" means a service that assists a member with acquiring the ability to use community resources such as stores, clinical professional services, recreational facilities, and government agencies. Services can be provided by a program manager or behavioral health aide.

(3) "Community reintegration" means a service that restores a member's independent community living skills including communication skills, vocational activities, community integration, social skills, establishment and maintenance of a community support network, and restoring daily structure. The service assists to restore the interaction between the member and their peers and to improve skills related to exhibiting appropriate behavior in a variety of environments including home, work, school, and community settings. Services

can be provided by a direct care rehabilitation worker, program manager, licensed or supervised in-training vocational rehabilitation counselor, psychologist, licensed clinical social worker (LCSW), licensed clinical professional counselor (LCPC), RN, or LPN.

(4) "Co-Occurring substance abuse" means services utilize the provision of stage-based treatment that is non-confrontational, considers interactions of mental illness and substance abuse, and has member-determined goals. This includes group and individual interventions, as well as facilitating the use of self-help groups and supportive recovery communities. Services can be provided by a licensed addiction specialist.

(5) "Family therapy" means therapy and/or treatment to a member's family is for the direct benefit of the member, in accordance with a member's needs and treatment goals identified in the member's ITP, and for the purpose of assisting in a member's recovery. This is a service that utilizes the same strategy of developing goals and includes family members and other significant others to address identified issues. The service reduces disability and restores a member to their previous functioning level by facilitating the development of skills needed for functioning in the community. The ability to acquire and apply these skills helps to prevent relapse and strengthen goal attainment. Services can be provided by a licensed or licensure candidate (with clinical supervision) psychologist, LCSW, or LCPC.

(6) "Group therapy" means a service that is much the same as individual therapy in terms of developing goals, objectives, and specific skills but utilizes a format which a group of members selected by the therapist are provided treatment in a group setting. The group may or may not have single therapeutic interests but is designed to treat a member by utilizing the group process and input of others in the group. Group therapy for rehabilitation of a member who has a mental illness or substance use disorder involves direct/indirect teaching by the therapist, and the guided or facilitated group interaction with one another, to bring about changes in functioning of all the group members. Group therapy is effective when focusing on the development of goals which can be reinforced by other group members and when social skills and social connections will assist a member in reaching their therapeutic goals. The service reduces disability by facilitating development of skills needed for functioning in the community. The ability to acquire and apply these skills helps to prevent relapse attainment. Services can be provided by a licensed or licensure candidate (with clinical supervision) psychologist, LCSW, or LCPC.

(7) "Independent living" means a service to assist a member with skills needed for daily living including maintenance of physical health and wellness, personal hygiene, safety, and symptom management. The service can be provided by a direct care rehabilitation worker, behavioral health aid, or program manager.

(8) "Individual therapy" means a service that utilizes one-to-one therapeutic interventions for a specified period of time in which the problem or issue impeding recovery or full functioning is defined and treated. A member and the therapist establish the overall objective (or outcome sought) and develop specific goals. The service reduces disability and develops or restores skills needed to function in life roles in the community. The ability to acquire and apply these skills helps prevent relapse and strengthen goal attainment. Services can be provided by a licensed or licensure candidate (with clinical supervision) psychologist, LCSW, or LCPC.

(9) "Medication administration, management, and monitoring" means a service to prescribe or administer medication in treating the primary symptoms of a member's psychiatric condition. This service is intended to include medication trials which are adequate in dose and duration, as well as assessments of the appropriateness of the member's existing medication regimen through record review, ongoing monitoring, and consultation. Medication management may include providing a member information concerning the effects, benefits, risks, and possible side effects of a proposed course of medication. Services can be provided by a RN, LPN, APRN, or psychiatrist.

(10) "Psychiatric/medical assessment and evaluation" means an ongoing service provided face-to-face with a member to determine psychiatric and social history, as well as the course of care and treatment goals required for the physical, nutritional, and psychological issues to restore previous functioning levels. Psychiatric assessment and evaluations can be completed by a licensed or licensure candidate (with clinical supervision) psychologist, LCSW, or LCPC.

(11) "Service coordination" means a service that assists a member and the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services necessary for treatment delivery. This service also includes coordination with community resources, including self-help and advocacy organizations, that promote recovery.

(12) "Vocational rehabilitation" means services that develop, direct, and provide work-related services including assessment of the effect of a member's mental illness on employment, as well as plan and implement strategies to enable each member to obtain and retain employment. Services can be provided by a Vocational Specialist or other mental health professional as determined by the department on a case-by-case basis.

Section 4 – Medicaid Substance Use Disorder (SUD)

The following clinical guidelines must be employed for each covered SUD service. Current forms required for utilization management are available on the department's website at: http://dphhs.mt.gov/amdd/FormsApplications. The forms for each service include the information regarding where and how to submit the form for the specific service.

(1) An appropriately licensed behavioral health professional or licensure candidates (under clinical supervision) must annually certify the member continues to meet the criteria for having a SUD. The assessment must document how the member meets the criteria for having a SUD.

(2) All Medicaid SUD services must be determined medically necessary by a licensed health care professional within the scope of their professional license; and

(3) The licensed behavioral health professional must use the most current edition of The ASAM Criteria to establish the appropriate level of care for placement into services.

SUD Definition

SUD means a member with a substance use disorder diagnosis from the most current edition of the DSM as the primary diagnosis.

High-Risk SUD Definition

For a member to receive more than 12 sessions of individual and 12 sessions of group therapy, a member must meet the criteria for High-Risk SUD. A member must have a diagnosis of dependence, as listed below, that has interfered with the member's functioning. In addition, the member must meet the American Society of Addiction Medicine's (ASAM) treatment criteria for Intensive Outpatient (ASAM 2.1) or Low Intensity Residential Services (ASAM 3.1). The provider must complete SUD Risk Rating and LOC worksheet to determine if the member meets the required criteria.

Alcohol Related Disorders

- Alcohol Use Disorder, Moderate or Severe, F10.20
- Alcohol Intoxication with Moderate or Severe Use Disorder, F10.220, F10.221
- Alcohol Withdrawal with Moderate or Severe Use Disorder, F10.230, D10.231, D10.232
- Alcohol-Induced Disorder with Moderate or Severe Use Disorder, F10.24, F10.250, F10.251, F10.26, F10.27, F10.281, F10.280, F10.281,F10.282, F10.288

Opioid Related Disorders

- Opioid Use Disorder, Moderate or Severe, F11.20
- Opioid Intoxication with Moderate or Severe Use Disorder, F11.220, F11.221, F11.222
- Opioid Withdrawal with Moderate or Severe Use Disorder, F11.23
- Opioid-Induced Disorder with Moderate or Severe Use Disorder, F11.24, F11.250, F11.251, F11.281, F11.282,F11.288

Cannabis Related Disorders

- Cannabis Use Disorder, Moderate or Severe, F12.20
- Cannabis Intoxication with Moderate or Severe Use Disorder, F12.220, F12.221, F12.222
- Cannabis-Induced Disorder with Moderate or Severe Use Disorder, F12.250, F12.251, F12.280, F12.288

Sedative, hypnotic, or anxiolytic related disorders

- Sedative, hypnotic or anxiolytic Use Disorder, Moderate or Severe, F13.20
- Sedative, hypnotic or anxiolytic dependence Intoxication with Moderate or Severe Use Disorder. F13.220, F13.221
- Sedative, hypnotic or anxiolytic Withdrawal with Moderate or Severe Use Disorder, F13.230, F13.231, F13.232
- Sedative, hypnotic or anxiolytic-Induced Disorder with Moderate or Severe Use Disorder, F13.24, F13.25, F13.251, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288

Cocaine related disorders

- Cocaine Use Disorder, Moderate or Severe, F14.20
- Cocaine Intoxication with Moderate or Severe Use Disorder, F14.220, F14.221, F14.222
- Cocaine Withdrawal with Moderate or Severe Use Disorder, F14.23
- Cocaine-Induced Disorder with Moderate or Severe Use Disorder, F14.24, F14.250, F14.251, F14.280, F14.281, F14.282, F14.288

Amphetamine or Other stimulant related disorders

- Amphetamine or Other Stimulant Use Disorder, F15.20
- Amphetamine or Other Stimulant Intoxication with Moderate or Severe Use Disorder, F15.220, F15.221, F15.222
- Amphetamine or Other Stimulant Withdrawal with Moderate or Severe Use Disorder, F15.23

- Amphetamine or Other Stimulant-Induced Disorder with Moderate or Severe Use Disorder, F15.24, F15.205, F15.251, F15.280, F15.281, F15.282, F15.288

Other Hallucinogen related disorders

- Other Hallucinogen Use Disorder, Moderate or Severe, F16.20
- Other Hallucinogen Intoxication with Moderate or Severe Use Disorder, F16.220, F16.221
- Other Hallucinogen-Induced Disorder with Moderate or Severe Use Disorder, F16.24, F16.250, F16.251, F16.280, F16.283, F16.288

Inhalant Related Disorders

- Inhalant Use Disorder, Moderate or Severe, F18.20
- Inhalant Intoxication with Moderate or Severe Use Disorder, F18.220, F18.221
- Inhalant-Induced Disorder with Moderate or Severe Use Disorder, F18.24, F18.250, F18.251, F18.27, F18.280, F18.288

Other (or unknown) substance related disorders

- Other (or unknown) Use Disorder, Moderate or Severe, F19.20
- Other (or unknown) Use Substance Intoxication with Moderate or Severe Use Disorder, F19.220, F19.221, F19.222
- Other (or unknown) Use Substance Withdrawal with Moderate or Severe Use Disorder, F19.230,F19.231, F19.232
- Other (or unknown) Use Substance-Induced Disorder with Moderate or Severe Use Disorder, F19.24. F19.250, F19.251, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288

Section 5 – Medicaid SUD Services

SUD Medically Monitored Intensive Inpatient (ASAM 3.7)

Definition:

ASAM 3.7 is medically managed/monitored inpatient treatment services provided in facilities of fewer than 16 beds. Members are provided a planned regimen of 24-hour professionally directed evaluation, observation, medical management/monitoring, and SUD treatment. These services are provided to members diagnosed with a SUD and whose subacute biomedical, emotional, behavioral, or cognitive problems are so severe they require inpatient treatment, but who do not need the full resources of an acute care general hospital. ASAM 3.7 includes the following components:

- individual therapy;
- group therapy;
- family therapy;
- nurse intervention and monitoring; and
- psychosocial rehabilitation

Provider Requirement:

ASAM 3.7 may be provided by a state-approved substance use disorder program and licensed to provide this level of care.

Medical Necessity Criteria:

Member must meet the SUD criteria as described in this Manual with a severity specifier of moderate or severe and meet The ASAM Criteria diagnostic and dimensional admission criteria for ASAM 3.7 level of care.

Prior Authorization:

Prior authorization is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to five days.

Service Requirements:

(1) Services must be provided in accordance with all state and federal regulations pertaining to the administration of the service.
(2) The provider must adhere to The ASAM Criteria service standards for service planning and level of care placement characteristic category standards. These categories include:
    (a) examples of service delivery and settings;
    (b) therapies;
    (c) support systems;
    (d) assessment/ITP review;
    (e) staff; and
    (f) documentation.

Continued Stay Review:

Continued stay review is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to five days.

Continued Stay Criteria:

Member must continue to meet the SUD criteria as described in this Manual with a severity specifier of moderate or severe and meet The ASAM Criteria diagnostic and dimensional admission criteria for ASAM 3.7 level of care.

Billing Requirements:

Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:

Prior authorization
Continued stay review request

SUD Clinically Managed High-Intensity Residential (ASAM 3.5)

Definition:

ASAM 3.5 is clinically managed residential treatment programs providing 24-hour supportive housing. Members are provided a planned regimen of 24-hour professionally directed SUD

treatment. These services are provided to members diagnosed with a SUD and whose emotional, behavioral, or cognitive problems are so significant they require 24-hour regimented therapeutic treatment, but who do not need the full resources of an acute care general hospital or a non-hospital inpatient setting. ASAM 3.5 includes 24-hour access to medical and emergency services and 24-hour staff present on-site. Services focus on stabilizing the member to transition to a recovery home, Day TX, or outpatient services. ASAM 3.5 includes the following components:

- individual therapy;
- group therapy;
- family therapy; and
- psychosocial rehabilitation.

Provider Requirements:
ASAM 3.5 may be provided by a state-approved substance use disorder program and licensed to provide this level of care.

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this Manual with a severity specifier of moderate or severe and meet The ASAM Criteria diagnostic and dimensional admission criteria for ASAM 3.5 level of care.

Prior Authorization:
Prior authorization is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 21 days.

Service Requirements:
(1) Services must be provided in accordance with all state and federal regulations pertaining to the administration of the service.
(2) Daily clinical services and service components listed above must be provided on-site at the ASAM 3.5 licensed facility where the member resides.
(3) The provider must adhere to The ASAM Criteria service standards for service planning and level of care placement characteristic category standards. These categories include:
    (a) examples of service delivery and settings;
    (b) therapies;
    (c) support systems;
    (d) assessment/ITP review;
    (e) staff; and
    (f) documentation.

Continued Stay Review:
Continued stay review is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to five days.

Continued Stay Criteria:

Member must continue to meet the SUD criteria as described in this Manual with a severity specifier of moderate or severe and meet The ASAM Criteria diagnostic and dimensional admission criteria for SUD Clinically Managed High-Intensity Residential (ASAM 3.5) level of care.

Billing Requirements:

Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:

Prior authorization
Continued stay review request

SUD Clinically Managed Low-Intensity Residential (ASAM 3.1)

Definition:

ASAM 3.1 is a licensed community-based residential home that functions as a supportive, structured living environment staffed 24 hours per day. Members are provided stability and skills building to help prevent or minimize continued substance use. SUD treatment services are provided on-site or off-site.

Clinical therapy hours provided in ASAM 3.1 are reimbursable through Medicaid for members who are Medicaid eligible pursuant to the High-Risk SUD requirements above. Room and board for the member's stay is a non-Medicaid services and is reimbursable through contract with AMDD.

Provider Requirements:

ASAM 3.1 may be provided by a state-approved substance use disorder program and licensed to provide this level of care.

Medical Necessity Criteria:

Member must meet the SUD criteria as described in this Manual with a severity specifier of moderate or severe and meet The ASAM Criteria diagnostic and dimensional admission criteria for ASAM 3.1 level of care.

Prior Authorization:

Prior authorization is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 90 days.

Service Requirements:

(1) Services must be provided in accordance with all state and federal regulations pertaining to the administration of the service.
(2) The provider must adhere to The ASAM Criteria service standards for service planning and level of care placement characteristic category standards. These categories include:
    (a) examples of service delivery and settings;
    (b) therapies;
    (c) support systems;
    (d) assessment/ITP review;
    (e) staff; and
    (f) documentation.

Continued Stay Review:
Continued stay review is required. The department or the UR Contractor may issue the authorization for as many days as deemed medically necessary up to 30 days.

Continued Stay Criteria:
The member must meet the High-Risk SUD definition.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Prior authorization
Continued stay review request

SUD Partial Hospitalization (ASAM 2.5)

Definition:
The purpose ASAM 2.5 therapeutic and behavioral interventions is to address the SUD in the structured setting and improve the member's successful functioning in the home, school, and/or community setting. SUD Partial Hospitalization includes a minimum of 20 hours of skilled treatment services per week (Minimum of 5 hours a day, 4 days a week). ASAM 2.5 includes the following components:

- individual therapy;
- group therapy;
- family therapy; and
- psychosocial rehabilitation.

Provider Requirements:
ASAM 2.5 may be provided by a state-approved substance use disorder program and licensed to provide this level of care.

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this Manual with a severity specifier of moderate or severe and meet The ASAM Criteria for diagnostic and dimensional admission criteria for ASAM 2.5 level of care.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Services must be provided in accordance with all state and federal regulations pertaining to the administration of the service.
(2) The provider must adhere to The ASAM Criteria service standards for service planning and level of care placement characteristic category standards. These categories include:
    (a) examples of service delivery and settings;
    (b) therapies;
    (c) support systems;
    (d) assessment/ITP review;
    (e) staff; and
    (f) documentation.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Member continues to meet admission criteria and demonstrates progress towards identified treatment goals and the reasonable likelihood of continued progress.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

SUD Outpatient (OP) Therapy (Individual and Group)

Definition:
SUD OP therapy services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided by a licensed addictions counselor or addictions counselor licensure candidates (under clinical supervision).
Provider Requirements:
OP therapy may be provided by a state-approved substance use disorder program or a private licensed mental health professional with substance use within their scope of practice.

Medical Necessity Criteria:
For the first 12 sessions of individual and 12 sessions of group per SFY:
(1) The member must have a recognized SUD diagnosis from the most current edition of the DSM.
(2) Outpatient therapy services that do not count towards the first 12 sessions are as follows:
    (a) psychiatric diagnostic or evaluative interview procedures;
    (b) outpatient psychotherapy with medication evaluation and management services;
    (c) pharmacological or medication management services; and
    (d) central nervous system assessments/tests or psychological testing performed by a physician or psychologists.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Group therapy services may not have more than eight members participating in the group.
(2) The provider must:
    (a) formulate an ITP on admission that identifies strength-based achievable goals and measurable objectives that are directed toward the alleviation of the symptoms and/or causes that led to the treatment;
    (b) document the response of the member to treatment and revise the ITP consistent with the clinical needs of the member; and
    (c) formulate a discharge plan regularly review and revise. The discharge plan must identify specific target dates for achieving specific goals, and defines criteria for conclusion of treatment.

Continued Stay Review:
For SUD OP therapy services more than 12 sessions per state fiscal year, for both individual and group, the provider must complete the Substance Use Disorder Risk Rating and Level of Care Worksheet and maintain it in the file of the member.

Continued Stay Criteria:
For sessions individual and group sessions more than 12 per state fiscal year:

(1) The member must meet the High-Risk SUD definition as defined in this Manual and:
   (a) the member has demonstrated investment in the therapeutic alliance and has agreed to the goals/objectives of the ITP; and
   (b) progress toward treatment goals has occurred as evidenced by measurable reduction of symptoms or behaviors that indicate continued responsiveness to treatment.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

Biopsychosocial Assessment

Definition:
A comprehensive assessment of a member's drug use history, medical, psychological, and social history based on the six dimensions of the ASAM Criteria.

Provider Requirements:
Biopsychosocial assessment may be provided by a state-approved substance use disorder program or a private licensed mental health professional with substance use within their scope of practice.

Medical Necessity Criteria:
The member must have been screened using an evidence-based screening instrument to identify the severity of substance use to make a determination for substance related disorders. The scored instrument must indicate a level of risk that requires further assessment.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
Services must be provided in accordance with all state and federal regulations pertaining to the administration of the service. In addition, the provider must adhere to The ASAM Criteria service standards.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Form:
Not applicable.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Definition:
An evidence-based approach to identify those members at risk for psychosocial or health care problems related to their substance use.

SBIRT is used to determine if a complete assessment and possible referral to treatment is needed. SBIRT must include an alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention (SBI) services.

Provider Requirements:
SBIRT may be provided by a state-approved substance use disorder program, physicians, or midlevel providers.

Medical Necessity Criteria:
Any Medicaid member may be screened.

Prior Authorization:
A prior authorization is not required.

Service Requirement:
(1) Licensed Behavioral Health Professionals are eligible to provide this service or supervise staff providing this service. Licensed staff must have a minimum of 4 hours training approved by the department related to SBIRT services.
(2) Non-licensed staff may deliver SBIRT services under supervision of a licensed staff member. All non-licensed staff must have a minimum of 8 hours training approved by the department related to SBIRT services.
(3) The staff providing this service needs to have proof of education/training in this practice.

(4) The following are approved screenings instruments:
    (a) adult:
        (i) AUDIT (Alcohol Use Disorder Identification Test);
        (ii) ASSIST (Alcohol, Smoking, and Substance Abuse Involvement Screening Test); or
        (iii) DAST – 10 (Drug Abuse Screening Test).
    (b) adolescent:
        (i) CRAFFT (Car, Relax, Alone, Forget, Family or Friends, Trouble); or
        (ii) SB2I (Screening to Brief Intervention).
    (c) pregnant women:
        (i) T-ACE (Tolerance, Annoyance, Cut Down, Eye Opener); or
        (ii) TWEAK (Tolerance, Worried, Eye Opener, Amnesia, K/Cut Down).
(5) A provider may submit other evidence-based screening instruments not listed above, with the supporting research documentation of the appropriateness of the instrument, for consideration and approval by the department.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

SUD Drug Testing

Definition:
Dip Strip or Saliva Collection, Handling, and Testing. Drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring of the ongoing status of a person who has been treated for addiction. As such, it is a part of medical care.

Provider Requirements:
Drug testing may be provided by a state-approved substance use disorder program.

Medical Necessity Criteria:
The member must meet the SUD criteria found in this Manual.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
Drug tests are limited to one test per 24-hour period per member. The need for drug testing services must be written into the ITP.

Continued Stay Review:
Continued stay review is not required.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

SUD Targeted Case Management (TCM)

Definition:
SUD TCM means as defined in the 42 CFR 440.169.

Provider Requirements:
SUD TCM may be provided by a state-approved substance use disorder program under contract with the department.

Medical Necessity Criteria:
(1) Member must meet the SUD criteria as described in this Manual and:
   (a) the member/representative gives consent and agrees to participate in TCM;
   (b) the need for TCM must be documented by a mental health professional; and
   (c) the member is receiving other adult behavioral health services.
(2) TCM services cannot be used for activities that are the responsibility of other systems.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
Services are to be delivered in accordance with 42 CFR 440.169, 42 CFR 441.18, and 42 CFR 431.51. For further detail, please see the most current version of the Montana Medicaid provider notice at http://medicaidprovider.mt.gov/

Continued Stay Review:

A continued stay review is required for services more than 96 units per member per state fiscal year. The department or the UR Contractor may issue the authorization for as many units as deemed medically necessary up to 24 units.

Continued Stay Criteria:
TCM is considered medically necessary when member has ALL of the following:
(1) The member continues to meet SUD criteria;
(2) Documentation of members participation and engagement in TCM;
(3) The member is allowing coordination of care with other providers and is involving family members where indicated and evidence of this is documented; and
(4) The member meets one of the following:
    (a) progress toward accessing needed services is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment and support services, improving severity of symptoms and functional impairment, and continued progress is expected; or
    (b) if progress is not documented, member has been re-assessed, treatment needs have been re-evaluated and changed with new linkage needs.

Billing Requirements:
Claims must be submitted on a CMS-1500 form. State-approved programs are required to bill CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and licensure candidates (under clinical supervision). Reimbursement will be according to the department's RBRVS fee schedule, adjusted for the provider type.

UR Required Forms:
Not applicable.

Section 6 - Retrospective Reviews/Quality Audit Review

(1) The department or the UR Contractor may perform retrospective clinical record reviews for two purposes:
    (a) to determine necessity of a provided service; or
    (b) as requested by the provider to establish the medical necessity for payment when the member has become Medicaid eligible retroactively or the provider has not enrolled in Montana Medicaid prior to the admission of the member.
(2) Retrospective reviews may be used to verify any of the following:
    (a) there is sufficient evidence of medical necessity for payment;
    (b) the member is receiving active and appropriate treatment consistent with standards of practice for the diagnosis and circumstances of the member; or
    (c) the criteria for having a SDMI and/or a SUD have been met.

Retrospective Reviews and Quality Audit Reviews by the Department
(1) The department or the UR Contractor will notify the provider by letter of the following:

(a) the purpose of the review; and
(b) what records are required, if applicable, and the specific period within which the full medical record is due to the department or the UR Contractor.

(2) Quality audit reviews are conducted as determined by the department.

Retrospective Reviews requested by the Provider

(1) A provider may request a retrospective review when the member becomes Medicaid eligible after the admission to the facility or program or when the provider has not enrolled in Montana Medicaid prior to the admission of the member:
(a) within 14 days after Montana Medicaid is established if prior to the discharge of the member; or
(b) within 90 days after Montana Medicaid is established if after the member has discharged.

(2) A provider must submit to the department or the UR Contractor:
(a) documentation that the member met medical necessity criteria; and
(b) a prior authorization and/or a certificate of need; if applicable.

Sanctions:

The department or the UR Contractor will provide written notification of deficiencies identified and may require a corrective action plan. If the provider fails to correct the deficiencies identified in the written notification, the department may impose sanctions based on review recommendations. The administrative rules which govern Medicaid provider sanctions are in the Administrative Rules of Montana, Title 37, chapter 85, subchapter 5.

Notification:

Following a review process, the department or the UR Contractor will send a letter with the determination to the provider and/or the member, legal representative, or authorized representative. The letter will contain the rationale for the determination and provide appeal information if there is a right to a fair hearing.

Formal Notification:

Formal notification is sent to the provider and/or the member/legal representative/authorized representative.

(1) Notification for technical denials will include:
(a) dates of service that are denied payment due to non-compliance with procedure;
(b) references to applicable regulations governing the review process;
(c) an explanation of the right, if any, to request an administrative review/fair hearing; and
(d) address and fax number of AMDD to request an administrative review, if applicable.

(2) Notification for clinical denial determination will include:
(a) the date or dates of service that is denied payment because the service requested did not conform with professional standards, lacked medical necessity based on the criteria, or was provided in an inappropriate setting;
(b) case specific denial rationale;
(c) date of notice of the denial determination, which is the mailing date;

(d) an explanation of the right to request a reconsideration review, and/or an administrative review/fair hearing;
(e) address and fax number of the department or the UR Contractor to request a reconsideration review; and
(f) address and fax number of AMDD to request an administrative review.

(3) The provider and/or member has the right to request an appeal.