

**Policy terminated because coverage is provided under equivalent Medicaid
Policy 8A: Enhanced Mental Health and Substance Abuse Services
(Substance Abuse Intensive Outpatient)**

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1.0 Description of the Procedure, Product, or Service

Intensive outpatient treatment in an Intensive Outpatient Program (IOP) is an alternative to inpatient hospital treatment or partial hospitalization of certain psychiatric or chemical dependency conditions as determined by patient's symptoms and level of functioning. An IOP must provide a comprehensive intake assessment including both mental health and chemical dependency. When treating children and adolescents, assessment of school performance and involvement with school personnel is essential. An IOP must offer multi-modal, multi-disciplinary structured outpatient treatment that is significantly more intensive than outpatient psychotherapy and medication management. Intensive outpatient programming is indicated for patients, often in crisis, who require structured, multi-modal treatment (individual therapy, group therapy, family and/or multi-family as appropriate and unless contraindicated, and psychoeducation) to achieve alleviation of symptoms and improved level of functioning. The program will have a variable length of treatment and will have the ability to reduce each participant's frequency of attendance as symptoms are alleviated and the individual is able to resume more of his/her usual life obligations. All treatment plans must be individualized, focusing on stabilization and transition to community based outpatient treatment and/or support groups as needed. The IOP must be administered by a licensed professional and sufficiently staffed to allow for rapid professional assessment of a change in mental status which could warrant a shift to a more intensive level of care or change in medication.

Treatment in an IOP does not count toward the 26 unmanaged outpatient psychotherapy visits.

2.0 Eligible Recipients

2.1 General Provisions

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

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

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

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

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

- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. All benefits for outpatient treatment in an Intensive Outpatient Program (IOP) are subject to case management requirements.
- b. IOP services must be provided face-to-face at least two hours per day up to five days per week.
- c. The care provided in an outpatient treatment in an Intensive Outpatient Treatment Program must be consistent with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders.

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

4.1 General Criteria

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

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

4.2 Specific Criteria

Intensive Outpatient treatment is not covered in the following situations:

- a. Treatment in an IOP setting for conditions not classified as psychiatric, emotional or substance abuse illnesses;
- b. Telephonic crisis management, when delivered as part of an IOP is not covered as a separate charge;
- c. In-home services less than two hours per day; or
- d. Travel time necessary for service delivery.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Approval by DMA's vendor is required prior to initiating IOP treatment, for continued IOP treatment AND for the following services if utilized during the intensive outpatient program stay:
 - 1. Biofeedback
 - 2. Hypnotherapy
 - 3. Psychological testing

- b. The DMA vendor will conduct a clinical review to determine medical necessity in response to the treating provider's request prior to admission to the intensive outpatient program.

5.2 Other

- a. In order to determine the medical necessity for continued stay, requests for subsequent reviews must be received prior to the expiration of any certified period.
- b. Professional fees for services by the attending psychiatrist or addictionologist or co-admitting psychologist are covered during any certified period when services are provided on separate days.

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

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

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

7.0 Additional Requirements

7.1 Compliance

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

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

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

C. Procedure Code(s)

Procedure Codes				
0900	0905	0906	0912	0944
0945				

HCPCS Codes	
S9480	H0015

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

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

F. Place of Service

Outpatient hospital; office; freestanding facility

G. Co-payments

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

H. Reimbursement

Providers must bill their usual and customary charges.