

**Policy terminated because coverage is provided under equivalent Medicaid
Policy 8D-1, Psychiatric Residential Treatment Facilities for Children under
the Age of 21**

Table of Contents

1.0 Description of the Procedure, Product, or Service..... 1

2.0 Eligible Recipients 1

 2.1 General Provisions 1

3.0 When the Procedure, Product, or Service Is Covered..... 1

 3.1 General Criteria..... 1

 3.2 Specific Criteria 2

4.0 When the Procedure, Product, or Service Is Not Covered..... 2

 4.1 General Criteria..... 2

 4.2 Specific Criteria 3

5.0 Requirements for and Limitations on Coverage 3

 5.1 Prior Approval 3

6.0 Providers Eligible to Bill for the Procedure, Product, or Service 4

7.0 Additional Requirements 4

 7.1 Compliance 4

8.0 Policy Implementation/Revision Information..... 4

Attachment A: Claims-Related Information 5

 A. Claim Type 5

 B. Diagnosis Codes 5

 C. Procedure Code(s)..... 5

 D. Modifiers..... 5

 E. Billing Units..... 5

 F. Place of Service 5

 G. Co-payments 5

 H. Reimbursement 5

1.0 Description of the Procedure, Product, or Service

Chemical dependency residential treatment is a facility-based level of care providing rehabilitation of substance abuse and dependency 24 hours a day, seven (7) days a week. Treatment in a Residential Treatment Center (RTC) is less restrictive than inpatient treatment and more restrictive than partial hospitalization or outpatient treatment.

Chemical dependency residential treatment centers provide active treatment of children and adolescents in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.

Treatment in the “least” restrictive environment is the therapeutic goal in RTC placement and continuing stay decisions.

Discharge planning should begin upon admission with specific interventions to foster reintegration into home and community; or to identify and arrange for other placement and/or follow-up treatment as may be appropriate – e.g., intensive outpatient programming, further outpatient treatment, etc.

2.0 Eligible Recipients

2.1 General Provisions

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

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

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

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

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

3.2 Specific Criteria

- a. All benefits for chemical dependency residential treatment are subject to the case management requirements.
- b. Chemical dependency residential treatment services are not covered unless all of the following conditions are met:
 1. The facility or program is licensed to provide chemical dependency residential services in the state in which services are provided.
 2. The facility or program must provide licensed supervision of all residents 24 hours per day, seven days per week.
 3. Residential treatment must be the least intensive level of care to meet the therapeutic needs of the recipient. It is expected that residential treatment is subsequent to adequate and appropriate treatment trials in alternative levels of care as appropriate – e.g., outpatient, partial hospitalization, or inpatient settings.
- c. Care provided consistent with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders.
- d. The residential treatment center's overall programming and treatment planning must have oversight by a Medical Director.
- e. Admission and discharge criteria must be specified in writing. At the direction of the attending or consulting psychiatrist or addictionologist, a comprehensive assessment and multi-disciplinary treatment plan must be developed within seven days of admission. Treatment plans must be multi-nodal, and individualized, reflecting frequent reviews and updates, based on the recipient's most current clinical presentation and response to treatment. Treatment and treatment planning must also address the psychiatric components of any dually diagnosed recipient. Therapies must be all inclusive of a range of social and recreational therapies with therapeutic programming being fully provided seven days a week. Educational services must be provided for children and adolescents. Active family/significant other involvement is a key element of treatment and family therapy is required unless contraindicated. Family therapy must be specified in the treatment plan and delivered at a frequency which meets the therapeutic need of the recipient and family, preferably face-to-face.
- f. The residential program must provided emergency psychiatric and medical services on site or by contact.

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

- a. Residential care for conditions classified primarily as psychiatric are not covered in chemical dependency residential treatment programs.
- b. Wilderness camps and stand-alone outdoor treatment programs are not covered. Outdoor components of residential chemical dependency treatment programs are covered only if facility based services are available as a part of the same program should a youth decompensate and need more supervision within a residential setting than the outdoor program can provide.
- c. Therapeutic boarding schools are not covered unless the program is licensed for psychiatric or chemical dependency residential treatment, and has licensed registered nurses who are present on-site 24 hours per day, and holds current national accreditation by a national accrediting body approved by DMA's vendor which include the Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for chemical dependency residential treatment. Approval by DMA's vendor is required prior to initiating treatment, for continued treatment stays and for the following services if utilized during the residential stay:
 - 1. Biofeedback
 - 2. Electroconvulsive therapy
 - 3. Hypnotherapy
 - 4. Psychological testing
- b. Prior to admission, DMA's vendor will conduct a clinical review with the treating provider(s) to determine the medical necessity for chemical dependency residential treatment.
- c. Upon request, the comprehensive assessment and treatment plan must be submitted by the seventh calendar day of admission to DMA/s vendor.
- d. Subsequent reviews will be conducted at least every 14 calendar days to determine the medical necessity for continued stay.
- e. Failure to comply with the approval process may result in ineligibility for reimbursement.

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

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Professional fees for services by the attending psychiatrist or addictionologist; or co-admitting psychologist are allowed during any approved period when services are provided and claims submitted for separate days.

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)

| Codes |
|-------|
| 0101 |
| 1001 |
| 1002 |

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

Inpatient Hospital, Residential Treatment 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.

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