Addictive and Mental Disorders Division
Medicaid Services Provider Manual for
Substance Use Disorder and Adult Mental Health

Effective May 1, 2018

Introduction

Purpose

The Addictive and Mental Disorders Division (AMDD) Medicaid Services Provider Manual (manual) provides information pertaining to substance use disorder (SUD) and adult mental health services available to Medicaid members. Requirements pertain to all Medicaid provider types, including Federally Qualified Health Centers (FQHC), Rural Health Centers, and FQHC look a-likes. This manual is adopted and incorporated into the Administrative Rules of Montana (ARM) 37.27.902 and ARM 37.88.101. This manual replaces the Medicaid portion of the current Chemical Dependency (CD) Provider Manual. The non-Medicaid portion of the CD Provider Manual remains in effect.

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

A member who is court ordered into services, or is otherwise required to receive services, must still meet the requirements for prior authorization and medical necessity criteria for Montana Medicaid reimbursement.

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.

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) "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.

(5) "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.

(6) "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.

(7) "Diagnostic and Statistical Manual of Mental Disorders (DSM)" means the American Psychiatric Association's classification of mental disorders manual. The DSM is the standard reference for clinical practice in the mental health field.

(8) "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.

(9) "Individualized Treatment Plan (ITP)" means as defined in ARM 37.106.1902 and ARM 37.106.1720.

(10) "MMIS" means the Medicaid Management Information System.

(11) "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.

(12) "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. Only a MHC can bill and receive reimbursement from Montana Medicaid for services provided by mental health professional licensure candidates. Information pertaining to becoming a licensed MHC is located at: http://dphhs.mt.gov/qad/Licensure.

(13) "Severe Disabling Mental Illness (SDMI)" means a member, 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. A member who meets the criteria in (a) or (b) below 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

If the member does not meet the criteria listed in (a) or (b) above, the provider must complete the SDMI Eligibility and LOI Worksheet to determine if the member meets the diagnostic and LOI criteria for the SDMI designation. The worksheet is located at: http://dphhs.mt.gov/amdd/FormsApplications. The provider must complete the SDMI Eligibility and LOI Worksheet annually and must keep it in the file/chart of the member. AMDD reserves the right to review the SDMI eligibility and LOI worksheet 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
- **Post-traumatic 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

(14) "Severity specifier" means a designation in the DSM to guide clinicians in rating the intensity, frequency, duration, symptom count, or other severity indicator of a disorder.

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

(16) "Substance Use Disorder (SUD)" means a member with a substance use disorder diagnosis from the most current edition of the DSM as the primary diagnosis.

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

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. Required forms are included in each service section. The forms for each service includes the information regarding where and how to submit the form and the documentation required 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) For services that are not acute services, 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 to the admission of the member will be technically denied. Requests received after the member has been admitted will be considered from the date the request was received by the department or the UR Contractor. The clinical reviewer will complete the review within three business days of receipt of complete information.

For acute services, the department or the UR Contractor must receive the complete prior authorization request within 36-hours of admission. Services which are designated as acute are:

(a) Acute Inpatient Hospital; and

(b) SUD Medically Monitored Intensive Inpatient (ASAM 3.7).

The clinical reviewer will complete the prior authorization review process within two business days of receipt of complete information for services that are acute, as described above.

(3) The clinical reviewer will 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.

(4) The board-certified physician will complete the review and determination within three business days of receipt of the information from the clinical reviewer.

(5) 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 or the UR contractor 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 or the UR Contractor 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 or the UR Contractor will not retroactively authorize days if a continued stay request is received late.

For acute and/or crisis services, the department or the UR Contractor must receive the complete continued stay request three days prior to the end of the current authorized period. Services which are designated as acute and/or crisis services are:

(a) Acute Inpatient Hospital;
(b) Crisis Stabilization Program; and
(c) SUD Medically Monitored Intensive Inpatient (ASAM 3.7).

The clinical reviewer will complete the continued stay review process within two business days of receipt of complete information for services that are acute and/or crisis, as described above.

(3) The following information must be submitted to the department or the UR Contractor 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 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. Payment is subject to Medicaid eligibility, applicable benefit provisions, and all 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 Request
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. A denial may be issued with additional days authorized for payment to allow for discharge planning. Adverse determinations may be appealed according to the reconsideration review process and/or administrative review/fair hearing

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 the department 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 physician reviewer 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 regarding 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.

Retrospective Review/Quality Reviews

(1) The department or the UR Contractor may perform retrospective clinical record reviews for two purposes:
   (a) to determine medical 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 Reviews

(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 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.

Administrative Review/Fair Hearing

Complete information about administrative reviews and fair hearings is found in ARM Title 37, Chapter 5 at: http://www.mtrules.org/gateway/ChapterHome.asp?Chapter=37%2E5.

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 claim 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. See the AMDD website at: http://dphhs.mt.gov/amdd.

Utilization Review, At-A-Glance

Below is a table that provides an At-A-Glance overview for utilization management of substance use disorder and adult mental health services. For services where limits apply, the provider may request an exception from the department to the limitation on a case-by-case basis. Exceptions will be reimbursed if the provider demonstrates why services are medically necessary over the unit limits and will maintain or improve the member's level of functionality or demonstrate a change of interventions/services. **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 and the documentation required for the specific service.

Adult Mental Health Services				
Service	Prior Authorization	Continued Stay Review	Limits	Diagnostic Criteria
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	Any mental health diagnosis from the current version of the DSM as the primary diagnosis
Acute PHP	Not Required	The provider must document in the file of the member every 90 days how the member meets the continued stay criteria	N/A	SDMI
ICBR	Required - up to 180 days	Required - up to 180 days	N/A	SDMI
PACT	Required - up to 180 days	Required - up to 180 days	N/A	SDMI
Crisis Stabilization Program	Not Required	Required for more than five days	N/A	Any mental health diagnosis from the current version of the DSM as the primary diagnosis
AGH	Required - up to 120 days	Required - up to 90 days	N/A	SDMI

Service	Prior Authorization	Continued Stay Review	Limits	Diagnostic Criteria
AFC	Not Required	Not Required	N/A	SDMI
Day TX	Not Required	Not Required	3 hours per day unless granted an exception	SDMI
DBT	Not Required	Not Required	N/A	SDMI
Mental Health OP Therapy	Not Required	Not Required	N/A	Any mental health diagnosis from the current version of the DSM as the primary diagnosis
CBPRS	Not Required	Not Required	2 hours per day -Individual 2 hours per day - Group unless granted an exception	SDMI
IMR	Not Required	Not Required	N/A	SDMI
MH TCM	Not Required	Not Required	N/A	SDMI
Substance Use Disorder Services				
Service	Prior Authorization	Continued Stay Review	Limits	Diagnostic Criteria
SUD Medically Monitored Intensive Inpatient (ASAM 3.7) Adult SUD Medically Monitored High Intensity Inpatient (ASAM 3.7) Adolescent	Required - up to five days	Required - up to five days	N/A	SUD

Service	Prior Authorization	Continued Stay Review	Limits	Diagnostic Criteria
SUD Clinically Managed High-Intensity Residential (ASAM 3.5) Adult SUD Clinically Managed Medium-Intensity Residential (ASAM 3.5) Adolescent	Required - up to 21 days	Required - up to five days	N/A	SUD
SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) Adult and Adolescent	Required - up to 90 days	Required - up to 30 days	N/A	SUD
SUD Partial Hospitalization (ASAM 2.5) Adult and Adolescent	Not Required	Not Required	N/A	SUD
SUD Intensive Outpatient Services (ASAM 2.1) Adult and Adolescent	Not Required	Not Required	N/A	SUD
SUD OP Therapy (ASAM 1.0) Adult and Adolescent	Not required	Not required	N/A	SUD

Service	Prior Authorization	Continued Stay Review	Limits	Diagnostic Criteria
SUD Biopsychosocial Assessment	Not Required	Not Required	N/A	Screened and scored instrument indicates a level of risk that requires further assessment
SUD Screening, Brief intervention, and Referral to Treatment	Not Required	Not Required	N/A	Any Medicaid member
SUD Drug Testing	Not Required	Not Required	N/A	SUD
SUD TCM	Not Required	Not Required	N/A	SUD

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 each service section for services that may not be provided concurrently. The department is entitled to recover any payment a provider is not entitled to pursuant to ARM 37.85.406.

Section 2 Medicaid Adult Mental Health Services

The SDMI clinical guidelines must be employed for covered Medicaid adult mental health services, unless otherwise indicated below. 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.

Acute Inpatient Hospital Services

Definition:
Acute 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.

Provider Requirements:
Acute Inpatient Hospital Services 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.

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.

Medical Necessity Criteria:
(1) Any mental health diagnosis from the current version of the DSM 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 of age, 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. No other services in this manual may be billed concurrently with Acute Inpatient Hospital Service with the exception of TCM. TCM may be provided concurrently up to 180 consecutive days.

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) Any mental health diagnosis from the current version of the DSM 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.

UR Required Forms:
Montana Medicaid Adult Certificate of Need (only needed for member 18-21 years of age)

Acute Partial Hospital Program (PHP)

Definition:
Acute PHP means a time limited active treatment program that offers therapeutically intensive, coordinated, and 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.
(2) The following services may not be provided concurrently with PHP:
  (a) Acute Inpatient Hospital;
  (b) ICBR;
  (c) PACT;
  (d) Crisis Stabilization Program;
  (e) AGH;
  (f) DBT;
  (g) MH and SUD OP Therapy;
  (h) CBPRS, during PHP program hours; and
  (i) IMR.

Continued Stay Review:
Not applicable.

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.

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:

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

Provider Requirements:
ICBR must be provided by a licensed MHC under contract with the department to provide this service. A provider must 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 following services may not be provided concurrently with ICBR:
(a) Acute Inpatient Hospital;
(b) PHP;
(c) PACT;
(d) Crisis Stabilization Program;
(e) AGH;
(f) AFC;
(h) CBPRS; and
(i) TCM.

Continued Stay Review:
See At-A-Glance.

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 Hospital Services 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.

Required UR Forms:
Mental Health Prior Authorization Review Form
Mental Health Continued Stay Review From

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, and inpatient hospital settings. PACT includes the following:

- psychiatric/medical assessment/evaluation;
- medication administration, management, and monitoring;

- individual, group, and family therapy;
- community psychiatric supportive treatment;
- CBPRS;
- co-occurring SUD treatment;
- peer support; and
- vocational rehabilitation.

Provider Requirements:
PACT must be provided by a licensed MHC and be approved by the department. For department approval the provider must submit the following:
(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) Two or more admissions within the past 12 months into acute psychiatric hospitals, crisis stabilization programs, 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) Co-occurring 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) PACT services are to be provided in the setting most convenient for the member.
(3) 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.
(4) The following services may not be provided concurrently with PACT:
  (a) Acute Inpatient Hospital;
  (b) PHP;
  (c) ICBR;
  (d) Crisis Stabilization Program;
  (e) AGH;
  (f) AFC;
  (g) DBT;
  (h) MH OP Therapy;
  (i) CBPRS;
  (j) IMR; and
  (k) TCM.

Continued Stay Review:
See At-A-Glance.

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.

UR Required Forms:
Mental Health Prior Authorization Review Form
Mental Health Continued Stay Review From

Crisis Stabilization Program, a/k/a Crisis Intervention Facility

Definition:
Crisis Stabilization Program 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 Acute 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. Crisis Stabilization Program 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:
Crisis Stabilization Program must be provided by a licensed MHC and must be approved by the department.

Medical Necessity Criteria:
Any mental health diagnosis from the current version of the DSM as the primary diagnosis and at least one of the following:
(1) Dangerousness to self as evidenced by behaviors that may include, but not be limited to any of the following:
   (a) self-injurious behavior or threats of same with continued risk without 24-hour supervision;
   (b) current suicidal ideation with expressed intentions and/or past history of carrying out such behavior with some expressed inability or aversion to doing so, or with ability to contract for safety;

(c) self-destructive behavior or ideation that cannot be adequately managed and/or treated at a lower level of care without risk to the patient's safety or clinical well-being; or
(d) history of serious self-destructive or impulsive, parasuicidal behavior with current verbalizing of intent to engage in such behavior, with the risk, as judged by a clinician, being significantly above the patient's baseline level of functioning.

(2) Dangerous to others, as evidenced by behaviors that may include expressed intent to harm others, current threats to harm others with expressed intentions of carrying out such behavior, with some expressed inability or aversion to doing so.

(3) Grave disability as exhibited by ideas or behaviors, as evidenced by behaviors that may include:
(a) mental status deterioration sufficient to render the member unable to reasonably provide for his/her own safety and well-being;
(b) an acute exacerbation of symptoms sufficient to render the member unable to reasonably provide for his/her own safety and well-being;
(c) deterioration in the member's function in the community sufficient to render the member unable to reasonably provide for his/her own safety and well-being;
(d) an inability of the member to cooperate with treatment combined with symptoms or behaviors sufficient to render the member unable to reasonably provide for his/her own safety and well being
(e) a clinician's inability to adequately assess and diagnose a member, as a result of the unusually complicated nature of a member's clinical presentation, with behaviors or symptoms sufficient to render the member unable to reasonably provide for his/her own safety and well-being, but not sufficient to require the intensity of inpatient treatment.

Prior Authorization:
Prior authorization is not required. Admission to Crisis Stabilization Program 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) Crisis Stabilization Program 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.

(2) The following services may not be provided concurrently with Crisis Stabilization Program:
(a) Acute Inpatient Hospital;
(b) PHP;
(c) ICBR;
(d) PACT;
(e) AGH;
(f) AFC; and
(g) Day TX;

Continued Stay Review:
See At-A-Glance

Continued Stay Criteria:
(1) Any mental health diagnosis from the current version of the DSM 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.

UR Required Forms:
Mental Health Continued Stay Review From

Adult Group Home (AGH)

Definition:
AGH 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. AGH services includes the following:

- independent living and skills training; and
- community adjustment training in the home or community.

Provider Requirements:
AGH must 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 impaired ability to perform daily living activities in an appropriate manner;
(3) The member exhibits symptoms related to the SDMI severe enough that a less intensive level of service would be insufficient to support the member in an independent living

setting 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) AGH must be provided in accordance with all applicable state and federal regulations and provide two hours of individual and/or group skills training per week.
(2) Members receiving AGH cannot be required to attend Day TX; it must be the member's choice to attend Day TX while receiving AGH.
(3) 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 state fiscal year (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.
(4) The following services may not be provided concurrently with AGH:
    (a) Acute Inpatient Hospital;
    (b) PHP;
    (c) ICBR;
    (d) PACT;
    (e) Crisis Stabilization Program;
    (f) AFC;
    (g) DBT;
    (h) CBPRS; and
    (i) IMR.

Continued Stay Review:
See At-A-Glance.

Continued Stay Criteria:
(1) The member continues to exhibit symptoms related to the SDMI severe enough that a less intensive level of service would be insufficient to support the member in an independent living setting and requires a structured treatment environment to be successfully treated 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) AGH is the least restrictive service to meet the clinical needs of the member.

UR Required Forms:
Mental Health Prior Authorization Review Form
Mental Health Continued Stay Review From

Adult Foster Care (AFC)

Definition:
AFC 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. AFC includes the following:

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

Provider Requirements:
AFC must 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 impaired ability to perform daily living activities in an appropriate manner.
(3) The member exhibits symptoms related to the SDMI that are severe enough that a less intensive level of service would be insufficient to support the member in an independent living setting 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:
(1) AFC must be provided in accordance with all applicable state and federal regulations.
(2) Members receiving AFC cannot be required to attend Day TX; it must be the member's choice to attend Day TX while receiving AFC.
(3) 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.

(4) The following services may not be provided concurrently with AFC:
   (a) Acute Inpatient Hospital;
   (c) ICBR;
   (d) PACT;
   (e) Crisis Stabilization Program; and
   (e) AGH.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

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.

Provider Requirements:
Day TX must 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) 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 member must have the capacity to engage in the structured settings of a rehabilitative and psychotherapeutic setting to engage in the skills activities of a Day TX program.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Services may be provided no less than two and up to three hours per day for 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 supervised;
  (b) a social or educational service that does not have or cannot reasonably be expected to have a 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.
(4) The following services may not be provided concurrently with Day TX:
  (a) Acute Inpatient Hospital; and
  (b) Crisis Stabilization Program.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

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:

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

Provider Requirements:
DBT must be provided by a licensed mental health professional or a licensed MHC.

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 the following:
   (a) dysregulation of emotion, cognition, behavior, and interpersonal relationships;
   (b) recurrent suicidal, para-suicidal, 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.
(7) The following services may not be provided concurrently with DBT:
   (a) Acute Inpatient Hospital;
   (b) PHP;
   (c) PACT; and
   (d) Crisis Stabilization Program.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Forms Required:
Not applicable.

Mental Health (MH) Outpatient (OP) Therapy

Definition:
MH Outpatient Therapy services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided.

Provider Requirements:
MH OP Therapy may be provided by a licensed mental health professional or a MHC.

Medical Necessity Criteria:
The member must have any mental health diagnosis from the current version of the DSM as the primary diagnosis.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Group therapy services may not have more than 16 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; and
    (b) document the response of the member to treatment and revise the ITP consistent with the clinical needs of the member.
(3) The following services may not be provided concurrently with MH OP Therapy:
    (a) Acute Inpatient Hospital;
    (b) PHP;
    (c) ICBR;
    (d) PACT; and
    (e) Crisis Stabilization Program.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

Community Based Psychiatric Rehabilitation Support (CBPRS)

Definition:
CBPRS is 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 must 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.
(3) The following services may not be provided concurrently with CBPRS:
    (a) Acute Inpatient Hospital;
    (b) PHP;
    (c) ICBR;
    (d) PACT;
    (d) Crisis Stabilization Program; and
    (e) AGH.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

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 licensed mental health professional, a MHC, or a paraprofessional or Certified Behavioral Health Peer Support Specialist under clinical supervision within a MHC. The clinical supervisor and 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, found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website, must be used in the provision of IMR:
    (a) IMR Practitioners Guide; and
    (b) IMR Educational Handouts.
    The SAMHSA website is located at: https://www.samhsa.gov/.
(2) Services must be based on a current comprehensive assessment and included as an intervention in the member's ITP.
(3) The following services may not be provided concurrently with IMR:
    (a) Acute Inpatient Hospital;
    (b) PHP;
    (c) ICBR;
    (d) PACT;
    (d) Crisis Stabilization Program; and
    (e) DBT.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

Adult Mental Health Targeted Case Management (TCM)

Definition:
TCM, as defined in the 42 CFR 440.169, is services furnished to assist members in gaining access to needed medical, social, educational, and other services. TCM includes the following assistance:

(1) Comprehensive assessment and periodic reassessment at least once every 90 days of an eligible member to determine service needs, including activities that focus on identification for any medical, educational, social or other services. These assessment activities include:
   (a) taking member history;
   (b) identifying the member's needs and completing related documentation; and
   (c) gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible member.

(2) Development and periodic revision of a specific care plan that is based on the information collected through the assessment that:
   (a) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   (b) includes activities such as ensuring the active participation of the eligible individual, and working with the member (or the member's authorized health care decision maker) and others to develop those goals; and
   (c) identifies a course of action to respond to the assessed needs of the eligible member.

(3) Referral and related activities, such as scheduling appointments for the member, to help the eligible member obtain needed services including activities that help link the member with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible member's needs, and which may be with the member, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
   (a) services are being furnished in accordance with the member's care plan;
   (b) services in the care plan are adequate; and
   (c) changes in the needs or status of the member are reflected in the care plan.

Provider Requirements:
MH TCM must 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 licensed 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:
(1) 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/.
(2) The following services may not be provided concurrently with TCM:
   (a) Acute Inpatient Hospital; with the exception of TCM. TCM may be provided concurrently up to 180 consecutive days;
   (c) ICBR;
   (d) PACT; and
   (e) Crisis Stabilization Program.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

Section 3 – Medicaid Substance Use Disorder (SUD) Services

The following clinical guidelines must be employed for each covered SUD service for members of all ages. An appropriately licensed mental health professional with SUD within the scope of their professional license, or a licensed addiction counselor, must certify the member continues to meet the criteria for having a SUD annually. The clinical assessment must document how the member meets the criteria for having a SUD. The most current edition of the ASAM criteria must be used to establish the appropriate level of care for placement into services.

SUD Medically Monitored Intensive Inpatient (ASAM 3.7) Adult
SUD Medically Monitored High Intensity Inpatient (ASAM 3.7) Adolescent

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:

- 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 licensed to provide this level of care.

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this manual and meet the ASAM criteria for 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:
See At-A-Glance.

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.

UR Required Forms:
Substance Use Disorder (SUD) Prior Authorization Form for Residential and Inpatient Services
Substance Use Disorder (SUD) Continued Stay Request Form for Residential and Inpatient Services

SUD Clinically Managed High-Intensity Residential (ASAM 3.5) Adult
SUD Clinically Managed Medium-Intensity Residential (ASAM 3.5) Adolescent

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. Services focus on stabilizing the member to transition into a recovery home, Day TX, or outpatient treatment. ASAM 3.5 includes the following:

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

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

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this manual and meet the ASAM criteria for 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 services listed above must be provided in accordance with ARM Title 37, Chapter 106, subchapter 14.
(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:

See At-A-Glance.

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.

UR Required Forms:

Substance Use Disorder (SUD) Prior Authorization Form for Residential and Inpatient Services
Substance Use Disorder (SUD) Continued Stay Request Form for Residential and Inpatient Services

SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) Adult and Adolescent

Definition:

ASAM 3.1 is a licensed community-based residential home that functions as a supportive, structured living environment. 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. 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 licensed to provide this level of care.

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this manual and meet the ASAM criteria for 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:
See At-A-Glance.

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 Low-Intensity Residential (ASAM 3.1) level of care.

UR Required Forms:
Substance Use Disorder (SUD) Prior Authorization Form for Residential and Inpatient Services
Substance Use Disorder (SUD) Continued Stay Request Form for Residential and Inpatient Services

SUD Partial Hospitalization (ASAM 2.5) Adult and Adolescent

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:

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

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

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this manual 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.

UR Required Forms:
Not applicable.

SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1) Adult and Adolescent

Definition:
IOP Therapy programs provide nine or more hours of services per week (adults) or six or more hours per week (adolescents) to treat multidisciplinary instability. Services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services.

Provider Requirements:

IOP Therapy must be provided by a state approved program or a licensed mental health professional with substance use within their scope of practice.

Medical Necessity Criteria:
The member must have any SUD diagnosis from the current version of the DSM as the primary diagnosis and meet the ASAM criteria for diagnostic and dimensional admission criteria for ASAM 2.1 level of care.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Group therapy services may not have more than 16 members participating in the group.
(2) Services must be provided in accordance with all state and federal regulations pertaining to the administration of the service.
(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:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

SUD Outpatient (OP) Therapy (ASAM 1.0) Adult and Adolescent

Definition:
SUD OP therapy services provide less than nine hours of service a week (adults) and less than six hours per week (adolescent) for recovery or motivational enhancement therapies/strategies. Services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided.

Provider Requirements:
SUD OP Therapy must be provided by a state approved program or a licensed mental health professional with substance use within their scope of practice.

Medical Necessity Criteria:
Member must meet the SUD criteria as described in this manual and meet the ASAM criteria for diagnostic and dimensional admission criteria for ASAM 1.0 level of care.

Prior Authorization:
Prior authorization is not required.

Service Requirements:
(1) Group therapy services may not have more than 16 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; and
   (b) document the response of the member to treatment and revise the ITP consistent with the clinical needs of the member.

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not applicable

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 must be provided by a licensed addictions counselor who is or is employed by a state-approved substance use disorder program or a 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:
Not applicable.

Continued Stay Criteria:
Not applicable.

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 must be provided by a state-approved substance use disorder program, a physician, or a midlevel practitioner.

Medical Necessity Criteria:
Any Medicaid member may be screened.

Prior Authorization:
A prior authorization is not required.

Service Requirement:
(1) Licensed professionals who are eligible to provide this service or supervise staff providing this service must have a minimum of four hours training approved by the department related to SBIRT services.
(2) The staff providing this service needs to have proof of education/training in this practice.
(3) 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).

(4) 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:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

SUD Drug Testing

Definition:
Dip Strip or Saliva Collection, Handling, and Testing are all considered SUD Drug 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 must 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:
Not applicable.

Continued Stay Criteria:
Not applicable.

UR Required Forms:
Not applicable.

SUD Targeted Case Management (TCM)

Definition:

SUD TCM, as defined in 42 CFR 440.169, is services furnished to assist members in gaining access to needed medical, social, educational, and other services. TCM includes the following assistance:

(1) Comprehensive assessment and periodic reassessment at least once every 90 days of an eligible member to determine service needs, including activities that focus on identification for any medical, educational, social or other services. These assessment activities include:
   (a) taking member history;
   (b) identifying the member's needs and completing related documentation; and
   (c) gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible member.

(2) Development and periodic revision of a specific care plan that is based on the information collected through the assessment that:
   (a) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   (b) includes activities such as ensuring the active participation of the eligible individual, and working with the member (or the member's authorized health care decision maker) and others to develop those goals; and
   (c) identifies a course of action to respond to the assessed needs of the eligible member.

(3) Referral and related activities, such as scheduling appointments for the member, to help the eligible member obtain needed services including activities that help link the member with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible member's needs, and which may be with the member, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
   (a) services are being furnished in accordance with the member's care plan;
   (b) services in the care plan are adequate; and
   (c) changes in the needs or status of the member are reflected in the care plan.

Provider Requirements:

SUD TCM must be provided by a state-approved substance use disorder program.

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 licensed 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 Montana Medicaid provider notice at http://medicaidprovider.mt.gov/

Continued Stay Review:
Not applicable.

Continued Stay Criteria:
Not Applicable.

UR Required Forms:
Not applicable.