## Addictive and Mental Disorders Division

Medicaid Manual for Substance Use Disorder and Adult Mental Health

| Section/Subsection | | Title/Content | Issued/Revised |
|---|---|---|---|
| | | **Introduction** | |
| | 001 | Purpose | 07/01/2020 |
| | 002 | Definitions | 07/01/2020 |
| **100** | | **Section 1- General Requirements** | |
| | 105 | Severe and Disabling Mental Illness | 07/01/2020 |
| | 110 | Substance Use Disorder | 07/01/2020 |
| | 115 | Assessments | 07/01/2020 |
| | 120 | Individualized Treatment Plans for Behavioral Health Treatment | 07/01/2020 |
| | 125 | Screening, Brief Intervention, and Referral to Treatment (SBIRT) | 07/01/2020 |
| | 130 | Progress Notes | 07/01/2020 |
| | 135 | Individualized Discharge Summary | 07/01/2020 |
| **200** | | **Section 2 – Utilization Management** | |
| | 205 | Requesting a Prior Authorization – Non-Acute Services | 07/01/2020 |
| | 206 | Requesting Auto Authorization – Acute Services | 07/01/2020 |
| | 206a | Auto-Authorization Quality Assurance | 07/01/2020 |
| | 210 | Requesting a Continued Stay Review – Non-Acute Services | 07/01/2020 |
| | 215 | Utilization Review Determinations and Notifications | 07/01/2020 |
| | 220 | Reconsideration Review Process | 07/01/2020 |
| | 230 | Integrated Service Delivery and Explanation of Concurrent Service | 07/01/2020 |
| **300** | | **Section 3 – Administrative Reviews** | |
| | 305 | Retrospective and Quality Reviews | 07/01/2020 |
| | 310 | Administrative Review, Fair Hearing, & Sanctions | 07/01/2020 |

| | | | |
|---|---|---|---|
| **400** | | **Section 4 – Medicaid Adult Mental Health Services** | |
| | 405 | MH Targeted Case Management (TCM) | 07/01/2020 |
| | 410 | Illness Management and Recovery Services (IMR) | 07/01/2020 |
| | 415 | Certified Behavioral Health Peer Support Services (CBHPSS) – Mental Health | 07/01/2020 |
| | 420 | Community Based Psychiatric Rehabilitation Support Services (CBPRS) | 07/01/2020 |
| | 425 | Mental Health (MH) Outpatient (OP) Therapy | 07/01/2020 |
| | 430 | Dialectical Behavior Therapy (DBT) | 07/01/2020 |
| | 435 | Day Treatment (Day TX) | 07/01/2020 |
| | 440 | Adult Foster Care (AFC) | 07/01/2020 |
| | 445 | Behavioral Health Group Home (BHGH) | 07/01/2020 |
| | 450 | Crisis Stabilization Program | 07/01/2020 |
| | 455 | Montana Assertive Community Treatment (MACT) | 07/01/2020 |
| | 460 | Program of Assertive Community Treatment (PACT) | 07/01/2020 |
| | 465 | Acute Partial Hospital Program (PHP) | 07/01/2020 |
| | 470 | Acute Inpatient Hospital | 07/01/2020 |
| **500** | | **Section 5 – Medicaid Substance Use Disorder (SUD) Services** | |
| | 505 | SUD Drug Testing | 07/01/2020 |
| | 510 | SUD Targeted Case Management | 07/01/2020 |
| | 515 | SUD Certified Behavioral Health Peer Support Services (CBHPSS) - Adult | 07/01/2020 |
| | 520 | SUD Outpatient (OP) Therapy (ASAM 1.0) | 07/01/2020 |
| | 525 | SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1) | 07/01/2020 |
| | 530 | SUD Partial Hospitalization (ASAM 2.5) | 07/01/2020 |

| | | | |
|---|---|---|---|
| | 535 | SUD Clinically Managed Low-Intensity Residential (ASAM 3.1) | 07/01/2020 |
| | 540 | SUD Clinically Managed High-Intensity Residential (ASAM 3.5) | 07/01/2020 |
| | 545 | SUD Medically Monitored Intensive Inpatient (ASAM 3.7) | 07/01/2020 |
| | 550 | Medication Assisted Treatment (MAT) | 07/01/2020 |

**Note: Please refer to AMDD Medicaid Services Provider Manual for SUD and Adult Mental Health for effective dates prior to 7-1-2020**

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*001* | **Subject:**<br>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 (RHC), Urban Indian Health Centers, and Tribal FQHC. Reimbursement for services are per their respective provider type reimbursement rules.

This manual is adopted and incorporated into the Administrative Rules of Montana (ARM) 37.27.902 and ARM 37.88.101.

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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*002* | **Subject:**<br>Definitions |

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

(1) **"The ASAM Criteria"** means the American Society of Addiction Medicine's (ASAM) guidelines for substance use disorders. The ASAM is standard reference for clinical practice in the substance use disorder health field.

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

(3) **"Care coordinator"** means the person that works with each member to ensure they receive the right care at the right time by coordinating services and referrals and tracking clinical outcomes. The care coordinator also works with members to identify social factors that may impede their treatment (like insecure or unsafe housing, lack of transportation, or food insecurity) and helps navigate the member and family toward community resources that can help address those factors.

(4) **"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.

(5) **"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.

(6) **"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.

(7) **"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.

(8) **"Crisis services"** are services that are provided with the goal of crisis stabilization.

(9) **"Continued Stay Review"** means a review used to determine that a members stay in a service is medically necessary and that care is being rendered at the appropriate level.

(10) **"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.

(11) **"Face-to-Face"** means services provided which is either:
(a) in person; or
(b) electronically. The transmission must:
(i) be two-way;
(ii) be interactive;
(iii) be real-time;
(iv) be simultaneous;
(v) provider for both audio and visual interaction.

(12) **"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.

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

(14) **"Licensure Candidate"** means as defined in ARM 24.219.301 and meets the requirements set forth in administrative rule Title 24, Chapter 219.

(15) **"MMIS"** means the Medicaid Management Information System.

(16) **"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.

(17) **"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.

(18) **"Prior Authorization"** means when a provider must obtain approval prior to the provision of a service to verify that the service is medically necessary.

(19) **"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.

(20) **"State-approved program"** means a program reviewed and accepted by the department to provide substance use disorder services under 53~~,~~-24-208, MCA.

(21) **"Targeted Case Management"** means as defined in the Code of Federal Regulations (CFR) 42 CFR 440.169.

(22) **"Tenancy Services"** means provides tenancy services by assessing the member's needs for housing assistance, helping them find and get housing, and securing other resources needed to maintain housing stability. This includes identifying roadblocks to housing, individual housing transition services, individual housing and tenancy sustaining services, acts as a liaison with landlords and housing authorities, makes sure the member has the appropriate documents and resources to rent (includes SSI/SSDI Outreach, Access, and Recovery (SOAR) activities and services), and provides state-level, housing related, collaborative activities for the member.

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

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*105* | **Subject:**<br>Severe and Disabling Mental Illness |

The SDMI clinical guidelines must be employed for covered Medicaid adult mental health services, unless otherwise indicated below. A licensed clinical mental health professional must certify the member continues to meet the criteria for having a SDMI annually. The clinical assessment must be updated annually and must document how the member meets or continues to meet the criteria for having a SDMI in order to bill Montana Medicaid.

(1) To be found to have a "Severe Disabling Mental Illness (SDMI)" a member must:

(a) be 18 years or older;

(b) 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

(c) has significant difficulty in community living without supportive treatment or services of a long-term or indefinite duration as a result of the member's diagnosis.

(2) A SDMI is chronic and persistent resulting in impaired functioning.

(3) 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 if:

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

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

- Schizophrenia, paranoid type, F20.0
- Schizophrenia, disorganized type, F20.1
- Schizophrenia, catatonic type, F20.2
- Schizophrenia, undifferentiated, F20.3
- Schizophrenia, residual type, F20.5
- Delusional disorder, F22
- Schizoaffective disorder, bi-polar type, F25.0

- Schizoaffective disorder, depressive type, F25.1

(4) 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.

(5) The provider must complete the SDMI Eligibility and LOI Worksheet annually and must keep it in the file/chart of the member.

(6) The department or the department's designee reserves the right to review the SDMI eligibility and LOI worksheet of all mental health providers using the SDMI designation.

(7) 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

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*110* | **Subject:**<br>Substance Use Disorder |

The 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.

To be found to have a "Substance Use Disorder (SUD)" a member must have a substance use disorder diagnosis from the most current edition of the DSM or ICD as the primary diagnosis.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*115* | **Subject:**<br>Assessments |

Each Medicaid member receiving behavioral health treatment must have a current comprehensive assessment that is updated annually with the following requirements:

(1) Must be conducted by an appropriately licensed clinical mental health professional or licensed addictions counselor trained in clinical assessments and operating within the scope of practice of their respective license.

(2) If the member had a psychosocial assessment completed by another provider within the past 12 months, and the provider determines it is not medically necessary to conduct another assessment, the provider must obtain the assessment for preparation of the individualized treatment plan and it must be kept in the member's file.

(3) Any collateral information needed to support information given by the member.

(4) For a member receiving SUD treatment services, the assessment must be relevant and organized according to the six dimensions of the ASAM Criteria.

(5) An assessment must include the following information in a narrative form to substantiate the member's diagnosis and must provide sufficient enough detail to individualize treatment plan goals and objectives:

(a) presenting problems and history of problem;

(b) family history (including substance use, social, religious/spiritual, medical, and psychiatric);

(c) developmental history (including pregnancy, developmental milestones, temperament);

(d) substance use and addictive behavior history;

(e) personal/social history (including school, work, peers, leisure, sexual activity, abuse, disruption of relationships, military service, financial resources, living arrangements, and religious and/or spiritual);

(f) legal history relevant to history of mental illness, substance use, and addictive behaviors (including guardianships, civil commitments, criminal mental health commitments, current criminal justice involvement, and prior criminal background);

(g) psychiatric history (including psychological symptoms, cognitive issues, and behavioral complications);

(h) medical history (including current and past problems, treatment, and medications)

(i) mental status examination (including memory and risk factors to include suicidal or homicidal ideation);

(j) physical examination (specifically focused on physical manifestations of withdrawal symptoms or chronic illnesses);

(k) diagnosis (diagnostic interview and impressions);

(l) survey of strengths, skills, and resources; and

(m) treatment recommendations

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*120* | **Subject:**<br>Individualized Treatment Plans for Behavioral Health Treatment |

Based upon the findings of the assessment(s), the Medicaid provider of mental health and/or SUD services must establish an individualized treatment plan for each member with the following requirements:

(1) Must be completed face-to-face and must include the member and/or the member's legal representative/guardian, if applicable, unless clinically indicated.

(2) Must be conducted by at least one appropriately licensed clinical professional, and should include persons who are involved in the member's treatment. Additional service providers must be contacted and encouraged to participate as clinically indicated.

(3) Must include the following elements:

(a) identify, at a minimum, the member's name, member's primary diagnosis and any other diagnoses that are relevant to the service provided, treatment provider, rendering provider if different, treatment plan date, treatment plan review due date, and treatment plan review date if applicable;

(b) identify treatment team members who are involved in the treatment;

(c) identify individualized, member strengths;

(d) identify the problem area that will be the focus of the treatment to include symptoms, behaviors, and/or functional impairments;

(e) identify the goals that are person-centered, long-term, recovery oriented;

(f) identify the objectives that are short-term designed to assist the member with accomplishing their goal that should be simple, straightforward, measurable, attainable, realistic, and time framed;

(g) describe the intervention and service with enough specificity to demonstrate the relationship between intervention and the stated objective;

(h) include the signature and date of the licensed clinical professional who completed the treatment plan; and

(i) state the criteria for discharge, including the member's level of functioning which will indicate when a service is no longer required.

(4) The treatment plan must be completed within 21 days of admission and reviewed and updated at least every 90 days for each member or when there is a change to the member's strengths, areas of concern, goals, objectives, or interventions. A change in level of care or referrals for additional mental health services must be included in the treatment plan.

(5) The treatment plan review must be comprehensive regarding the member's response and progress to treatment and result in either an amended treatment plan or a statement of the continued appropriateness of the existing plan. The documentation must include a description of the member's functioning and justification for member's goal(s).

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*125* | **Subject:**<br>Screening, Brief Intervention, and Referral to Treatment (SBIRT) |

## Definition

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based primary care intervention to identify those members at risk for psychosocial or health care problems related to their substance use. Montana Medicaid encourages its use by community providers to determine if a complete assessment and possible referral to treatment is needed.

## Requirements

SBIRT has the following requirements:

(1) Must include an alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention (SBI) services.

(2) Must be provided by a state-approved substance use disorder program, a physician, or a midlevel practitioner.

(3) Services can be provided by licensed professionals or licensure candidates who are eligible to provide this service or supervise staff providing this service.

(4) Appropriate staff providing this service must have a minimum of four hours training approved by the department related to SBIRT services.

(5) The staff providing this service needs to have proof of education/training in this practice.

(6) The following are approved screenings instruments for adults:

(a) AUDIT (Alcohol Use Disorder Identification Test);
(b) ASSIST (Alcohol, Smoking, and Substance Abuse Involvement Screening Test); or
(c) DAST – 10 (Drug Abuse Screening Test).

(7) The following are approved screenings instruments for adolescents:

(a) CRAFFT (Car, Relax, Alone, Forget, Family or Friends, Trouble); or

(b) SB2I (Screening to Brief Intervention).

(8) The following are approved screenings instruments for pregnant women:
(a) T-ACE (Tolerance, Annoyance, Cut Down, Eye Opener); or
(b) TWEAK (Tolerance, Worried, Eye Opener, Amnesia, K/Cut Down).

(9) 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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*130* | **Subject:**<br>Progress Notes |

The Medicaid provider of mental health and/or SUD services must complete progress notes for each member in accordance with *ARM 37.85.414 Maintenance of Records and Auditing*.

All progress notes and treatment records are individualized to the member. Progress notes should be legible and include basic information detailing diagnostic findings, member's past and current status, and progress. Basic information contained in a progress note can include:

(a) member's name and other identifying information;

(b) primary diagnosis;

(c) service/program or CPT code provided during the service/session;

(d) date of service;

(e) time in and out or length of service for service that have a time requirement;

(f) treating provider's name with credentials; and

(g) treating provider's signature with date of note completion.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*135* | **Subject:**<br>Individualized Discharge Summary |

The Medicaid provider of mental health and/or SUD services must complete an individualized discharge summary for each member with the following requirements:

(1) Discharge summary must be completed and filed in the clinical record within one month of the date of the member's formal discharge from services or within three months of the date of the member's last services when no formal discharge occurs.

(2) For cases left open when a member has not received services for over 30 days, documentation must be entered into the record indicating the reason for leaving the case open.

(3) The discharge summary must include:

(a) the reason for discharge;

(b) a summary of the services provided by the provider including recommendations for aftercare services and referrals to other services, if applicable;

(c) an evaluation of the member's progress as measured by the treatment plan and the impact of the services provided; and

(d) the signature of the staff person who prepared the summary and the date of preparation.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*205* | **Subject:**<br>Requesting Prior Authorization – Non-Acute Services |

## Procedure for Requesting Prior Authorization

**Providers must use Mountain-Pacific Quality Health Qualitrac Utilization Management Portal**

(1) The department or the department's designee 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 department's designee 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 returned to the provider with an indication that the provider will need to resubmit the request no earlier than five days prior to the admission.

(3) Requests received after the member has been admitted into services will be considered from the date the request was received by the department or the department's designee

(4) For services that are not acute, the clinical reviewer will complete the review within three business days of receipt of complete information.

(5) 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, that will result in a generated 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.

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

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*206* | **Subject:**<br>Requesting Auto-Authorization – Acute Services |

(1) For acute services, the provider may implement an auto-authorization process for ensuring timely authorizations for the following services:

(a) Out-of-State Acute Psychiatric Hospitalization;

(b) SUD Medically Monitored Intensive Inpatient (ASAM 3.7); and

(c) Crisis Stabilization Program.

(2) Providers must use Mountain-Pacific Quality Health Qualitrac Utilization Management Portal to submit all auto-authorization requests.

(3) The department or the department's designee 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.

(4) Requests received after the member has been admitted into services will be considered from the date the request was received by the department or the department's designee.

**Out-of-State Acute Psychiatric Hospitalization**

Initial Request:

(1) Approved if following criteria is indicated and attested to by submitter:

(a) any Mental Health DSM 5 diagnosis as primary; and

(b) danger to self or others not appropriately treated at a lower level of care.

(2) Approved for 60 days.

(3) The following documentation must be provided at time of request or no later than 1 business day following submission:

(a) intake paperwork from appropriately licensed clinician indicating diagnostic impression and risk of harm to self or others if not treated at this level of care.

Subsequent Requests - must be submitted using the manual process.

**SUD Medically Monitored Intensive Inpatient (ASAM 3.7)**

Initial Request

(1) Approved if following criteria is indicated and attested to by submitter:

(a) meets SUD criteria as described in this provider manual;

(b) meets ASAM 3.7 criteria:

(i) high Risk Rating in Dimension 1 (Acute Intoxication and/or Withdrawal Potential); and

(ii) evaluation of Dimensions 2-6 as appropriate.

(2) Approved for 3 days.

(3) The following documentation must be provided at time of request or no later than 1 business day following submission:

(a) intake paperwork from appropriately licensed clinician indicating diagnostic impression and ASAM level of care assessment.

(b) evidence of at least one of the following:

(i) active intoxication at time of admission as indicated by BAL or UDS results; or

(ii) imminent withdrawal risk as indicated by documented history of previous withdrawals, if seizure history, include dates; or

(iii) active withdrawal symptoms as indicated by CIWA, COWS and/or administered medication list.

Subsequent Request (limit of one subsequent via auto-authorization, then manual requests must be submitted):

(1) Approved if the following criteria is indicated and attested to by submitter:

(a) meets SUD criteria as described in this manual; and

(b) meets ASAM 3.7 criteria:

(i) high Risk Rating in Dimension 1 (Acute Intoxication and/or Withdrawal Potential); and

(ii) evaluation of Dimensions 2-6 as appropriate.

(2) Approved for 3 days.

(3) The following documentation must be provided at time of request or no later than 1 business day following submission:

(a) clinical paperwork indicating evidence of at least one of the following:

(i) sustained imminent withdrawal risk as indicated by documented history of previous withdrawals, if seizure history, include dates; or

(ii) sustained active withdrawal symptoms as indicated by CIWA, COWS and/or administered medication list.

(b) Current treatment plan describing progress with clinical interventions and any critical incidents.

(c) Medication list, with explanation of any changes.

(d) Discharge plan including projected discharge date.

**Crisis Stabilization Program**

Initial Request (to be provided for days six through eight):

(1) Approved if following criteria is indicated and attested to by submitter:

(a) any Mental Health DSM 5 diagnosis as primary and both of the following:

(i) active treatment is occurring which is focused on stabilizing or reversing symptoms that meet admission criteria; and

(ii) a lower level of care is inadequate to meet the member's treatment or safety needs.

(b) At least 1 of the following:

(i) there is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the inpatient setting; or

(ii) there is a high likelihood of either risk to the member's safety, clinical well-being, or further significant acute deterioration in the member's condition without continued care and lower levels of care are inadequate to meet these needs; or

(iii) the appearance of new impairments meeting admission guidelines.

(2) Approved for eight days.

(3) Following documentation must still be provided at time of request or no later than 1 business day following submission:

(a) intake paperwork from appropriately licensed clinician indicating diagnostic impression and initial plan of care

(b) discharge plan indicating projected discharge date; and

(c) treatment notes indicating active treatment focused on stabilizing conditions meeting admission criteria and clinical justification for treatment (days six through eight).

Subsequent Requests (limit of two subsequent request via auto-authorization, then manual requests must be submitted):

(1) Approved if following criteria is indicated and attested to by submitter:

(a) any mental health DSM 5 diagnosis as primary and both of the following:

(i) active treatment is occurring which is focused on stabilizing or reversing symptoms that meet admission criteria; and

(ii) a lower level of care is inadequate to meet the member's treatment or safety needs.

(b) at least 1 of the following:

(i) there is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the inpatient setting; or

(ii) there is a high likelihood of either risk to the member's safety, clinical well-being, or further significant acute deterioration in the member's condition without continued care and lower levels of care are inadequate to meet these needs; or

(iii) the appearance of new impairments meeting admission guidelines.

(2) Approved for 3 days.

(3) Following documentation must still be provided at time of request or no later than 1 business day following submission:

(a) clinical paperwork (assessments or treatment notes) from appropriately licensed clinician indicating any changes to diagnostic impression and justification for continued services at this level of care;

(b) current treatment plan describing progress with clinical interventions and any critical incidents;

(c) medication list, with explanation of any changes; and

(d) discharge plan including projected discharge date.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*206a* | **Subject:**<br>Auto-Authorization – Quality Assurance (QA) |

(1) The department or the department's designee will review either 100% or a sample size, as determined below, of appropriate use of auto-authorization submitted by providers.

(2) Each provider will be scored for appropriate application of the medical necessity criteria for each of the acute services listed in Policy #206.

(3) The following scoring rubric will be utilized to determine a provider's readiness and continued use of the auto-authorization process:

**Each request will be scored on a scale of 1-4 with consideration paid to timely filing, completeness of documentation, and selected medical necessity criteria being supported**

- 1 = untimely, documentation not present, and medical necessity criteria is not supported; would have received request for additional information if manual review.
- 2 = timely, and/or documentation missing, and/or unclear if medical necessity criteria is supported; would have received request for additional information if manual review.
- 3 = timely, incomplete documentation, though medical necessity criteria is supported; would have received request for additional information if manual review.
- 4 = timely, and all documentation is present, and medical necessity criteria is supported; would NOT have received request for additional information if manual review.

(4) The department or the department's designee will run reports on a monthly basis for the preceding month on appropriateness of all auto-authorizations and assign the following ratings for providers:

- Green = 100% of auto-authorizations scored between a three or four.

  The provider may continue auto-authorizations with no restrictions, if more than two months in a row of Green, then move to a sample size scoring rubric instead of 100% QA.

- Yellow = Less than 50% of auto-authorizations scored a one or two.

  The department or the department's designee will monitor for trends. If more than two months with a plateau or an increase in the percent of ratings with a one or a two, the provider may be moved to a red level.

- Red = More than 50% of auto-authorizations scored a one or two.

  The department or the department's designee will remove auto-authorizations for one month and the provider must return to a manual review. The provider can return to auto-authorizations after 30 consecutive days if less than 10% of manual authorizations have a need for Requests for Information.

**If a provider must be moved to a manual review, the following requirements must be followed:**

(1) The department or the department's designee may issue the prior authorization for as many days as deemed medically necessary up to the maximum number of days allowed as stated for each service requiring authorization. Authorization for less than the maximum days does not constitute a partial denial of services.

(2) The department or the department's designee must receive the complete prior authorization request within 3 days of admission.

(3) The clinical reviewer will complete the prior authorization review process within two business days of receipt of complete information.

(4) 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, that will result in a generated notification to all appropriate parties if the request meets the medical necessity criteria; or

  (c) defer the case to a board-certified physician for review and determination if the prior authorization request does not appear to meet the medical necessity criteria.

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

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*210* | **Subject:**<br>Requesting a Continued Stay Review – Non-Acute Services |

## Procedure for Requesting a Continued Stay Review

**Providers must use Providers must use Mountain-Pacific Quality Health Qualitrac Utilization Management Portal to submit all Continued Stay Review requests.**

(1) The department or its designee 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 its designee 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 returned to the provider with an indication that the provider will need to resubmit the request no earlier than five days prior to the admission.

(3) 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 its designee will not retroactively authorize days if a continued stay request is received late.

(4) For acute and/or crisis services, see Policy 266/206a.

(5) For services that are not acute services, the clinical reviewer will complete the continued stay review process within three business days of receipt of all required information.

(6) The following information must be submitted to the department or its designee for each continued stay review:

(a) changes to current DSM/ICD diagnosis;

(b) justification for continued services at this level of care;

(c) a description of mental health and/or substance use disorder interventions and critical incidents;

(d) a copy of the member's most recent individualized treatment plan (ITP);

(e) a list of current medications and rationale for medication changes, if applicable; and

(f) a projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan.

(8) 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) 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.

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

(10) After a denial, a new continued stay request may be submitted only if there is new clinical information.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br>**Treatment Bureau**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*215* | **Subject:**<br>Utilization Review Determinations and Notifications |

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

**Authorization**

An authorization determination indicates that the utilization review resulted in approval of provider requested services or services units as deemed medically necessary up to the maximum number of allowed days as stated for each service. 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 department's designee.

**Request for Information**

A request for information 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 stay authorization was not possible because of an equipment failure or malfunction of the department or the department's designee 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 department's designee. 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.

**Notification**

Following a review process, the department or the department's designee will send a letter with the determination to the member, legal representative, or authorized representative and the provider, as appropriate. 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 member/legal representative/authorized representative and the provider, as appropriate.

(1) Notification for technical denials will include:

(a) dates of service that have been 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 the Addictive and Mental Disorders Division (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 department's designee to request a reconsideration review; and

(f) address and fax number of AMDD to request an administrative review.

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

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br>**Treatment Bureau**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*220* | **Subject:**<br>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. To request a reconsideration review, a provider must submit a request to the department's designee as directed in the determination letter.

There are two types of reconsideration reviews:

**(1) 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.

(a) The Peer-to-Peer Review is based upon the original clinical documentation and may consider clarification or updates.

(b) The Peer-to-Peer Review must be:

(i) requested within ten business days of the adverse determination date; and

(ii) scheduled by the physician reviewer within five business days of the request.

**(2) Desk Review:** A Desk Review may be requested 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.

(a) The Desk Review is based upon the original clinical documentation and any additional supporting documentation.

(b) The Desk Review must be:

(i) requested within 15 business days of the most recent adverse determination date; and

(ii) 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's designee 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 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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*230* | **Subject:**<br>Integrated Service Delivery and Explanation of Concurrent Service Reimbursement |

The department encourages integrated services for members who have a co-occurring mental health and SUD diagnosis. Integrated treatment of co-occurring diagnosis is a best practice and recommended by SAMSHA. We encourage services with bundled reimbursement to provide integrated care to address the full person.

Many of the services have bundled rates. Bundled rates include multiple service components for a single rate, typically provided on a daily or per diem schedule. Medicaid does not allow concurrent reimbursement of services that share any service components because of federal Medicaid regulations which prohibit duplicative billing. 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. This does not prohibit members who have co-occurring diagnoses from receiving both mental health services and SUD treatment. This encourages integrated service delivery through the provision of co-occurring mental health services and SUD treatment to members with co-occurring disorders and prohibits the separate reimbursement for duplicative services outside of the bundled rate.

Please reference each service section for services that are provided as part of a bundled service rate and may not be reimbursed separately to ensure duplicate billing does not occur. If a provider has questions regarding duplicative billing, please contact AMDD for assistance in determining if a concurrent service is duplicative to prevent Medicaid recovery of for duplicate billing.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*305* | **Subject:**<br>Retrospective and Quality Reviews |

(1) The department or its designee 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.

**Quality Reviews**

(1) The department or its designee 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 its designee.

(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 it's designee:

   (a) documentation that the member met medical necessity criteria; and

   (b) a prior authorization and/or a certificate of need; if applicable.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*310* | **Subject:**<br>Administrative Review, Fair Hearing, & Sanctions |

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.

A provider requesting an administrative review for denied claims, 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. Go to the AMDD website at: https://dphhs.mt.gov/amdd.aspx.

**Sanctions**

The department or it's designee 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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*405* | **Subject:**<br>Mental Health Targeted Case Management (TCM) - Adult |

## 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 to ensure the active participation of the eligible individual member, 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 them 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 may also 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.

## Medical Necessity Criteria

(1) Member must meet the Severe and Disabling Mental Illness (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 clinical mental health professional; and

(c) the member is receiving other adult mental health or substance use disorder services.

(2) TCM services cannot be used for activities that are the responsibility of other systems.

## Provider Requirements

In order to bill Montana Medicaid, MH TCM must be provided by a licensed MHC.

## 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 go to the most current version of the TCM Montana Medicaid provider notice at http://medicaidprovider.mt.gov/.

(2) MH TCM is not a bundled service and must be billed using the appropriate HCPCS code.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*410* | **Subject:**<br>Illness Management and Recovery Services (IMR) |

## Definition

Illness Management and Recovery Services (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.

## Medical Necessity Criteria

(1) Member must meet the Severe and Disabling Mental Illness (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.

## Provider Requirements

IMR may be provided by a licensed mental health professional, a licensed MHC, or a paraprofessional or Certified Behavioral Health Peer Support Specialist under clinical supervision within a licensed MHC. The clinical supervisor and the practitioner providing IMR services must be trained in IMR services.

## 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) IMR is not a bundled service and must be billed using the appropriate HCPCS code.

(3) Medically necessary services that are billed must be documented in the individualized treatment plan in the member's file.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*415* | **Subject:**<br>Certified Behavioral Health Peer Support Services (CBHPSS) – Mental Health |

## Definition

CBHPSS is a face-to-face service provided one-to-one to promote positive coping skills through mentoring and other activities that assist a member with a SDMI diagnosis to achieve their goals for personal wellness and recovery. The purpose is to help members through a process of change to improve their health and wellness, live a self-directed life, and strive to reach their full potential.

## Medical Necessity Criteria

Member must meet the Severe and Disabling Mental Illness (SDMI) criteria as described in this manual.

## Provider Requirements

(1) In order to bill Montana Medicaid, CBHPSS must be provided by a Certified Behavioral Health Peer Support Specialist, certified by the Montana Board of Behavioral Health (BBH) and provided by a licensed MHC, Federally Qualified Health Center, Rural Health Clinic, Urban Indian Health Center, or IHS Tribal 638.

(2) Mental Health Centers must:

(a) ensure staff are certified by the BBH;

(b) develop policies and procedures for initial and on-going staff training for these services;

(c) assure ongoing communication and coordination of the treatment team to ensure the services provided are updated as needed; and

(d) establish the frequency of services as determined by needs and desires of the member.

## Service Requirements

(1) CBHPSS must be a direct service provided in an individual setting.

(2) Group peer support is not a Medicaid reimbursable service.

(3) Transportation of a member in and of itself does not constitute an allowable direct service.

(4) The individualized treatment plan (ITP) must include peer support goals that address the member's primary behavioral health needs.

(5) Individual CBHPSS is not a bundled service and must be billed using the appropriate HCPCS code.

(6) CBHPSS includes the following:

(a) coaching to restore skills;

(b) self-advocacy support;

(c) crisis/relapse support;

(d) facilitating the use of community resources; and

(e) restoring and facilitating natural supports and socialization.

(7) It is not required that each member receiving CBHPSS receive every service listed above. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

(8) BHPS services must be delivered by a BHPS whose primary responsibility is the delivery of BHPS services.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*420* | **Subject:**<br>Community Based Psychiatric Rehabilitation Support Services (CBPRS) |

## Definition

CBPRS is face-to-face, intensive behavior management and stabilization services in the 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 functioning. 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.

## Medical Necessity Criteria

Member must meet the Severe and Disabling Mental Illness (SDMI) criteria as described in this manual and is receiving other adult mental health services.

## Provider Requirements

CBPRS must be provided by a licensed MHC.

## Service Requirements

(1) CBPRS services are not bundled and are billed using the appropriate HCPCS code.

(2) CBPRS services may be provided to an individual or in a group setting.

(3) Medically necessary services that are billed must be documented in the individualized treatment plan in the member's file.

(4) Daily progress notes must include the time in and out for both individual and group services.

(5) Individual CBPRS may be reimbursed up to maximum of 2 hours of group and 2 hours of individual in a 24-hour period, unless granted an exception by the department.

(6) Group CBPRS may include up to 8 adults in the group per one staff.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*425* | **Subject:**<br>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.

## Medical Necessity Criteria

The member must have any mental health diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis.

## Provider Requirements

MH OP Therapy may be provided by a master's level licensed mental health professional. Licensure candidates may provide MH OP Therapy when employed by a licensed Mental Health Center.

## Service Requirements

(1) Group therapy services may not have more than 16 members participating in the group.

(2) Services must be based on a current comprehensive assessment and included as an intervention in the member's individualized treatment plan (ITP), as described in this manual.

(3) MH OP is not a bundled service and must be billed using the appropriate outpatient therapy codes.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*430* | **Subject:**<br>Dialectical Behavioral Therapy (DBT) |

## Definition

DBT is an evidence-based service that is a comprehensive, cognitive-behavioral treatment. DBT can be provided by any licensed clinical mental health professional who is trained to provide it.

## Medical Necessity Criteria

The member must meet the Severe and Disabling Mental Illness (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, and/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.

## Provider Requirements

DBT must be provided by a licensed clinical mental health professional or a licensed MHC.

## Service Requirements

(1) Services must be based on a current comprehensive assessment and included as an intervention in the member's individualized treatment plan (ITP), as described in this manual.

(2) DBT must be provided by a licensed clinical mental health professional or a licensure clinical candidate (under clinical supervision), who has at least six hours of classroom DBT training within the past 3 years, from a qualified DBT training program.

(3) The licensed clinical mental health professional or licensure clinical 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) DBT services are not a bundled service and are billed using the appropriate HCPCS code.

(5) DBT services includes the following:

(a) intensive individual DBT therapy;

(b) DBT - skill development group; and

(c) DBT - skills development individual.

(6) It is not required that each member receiving DBT receive every service listed above. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

(7) 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.

(8) 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.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*435* | **Subject:**<br>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 licensed clinical mental health professional 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.

## Medical Necessity Criteria

The member must meet the Severe and Disabling Mental Illness (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.

## Provider Requirements

Day TX must be provided by a licensed MHC.

## 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 as described in this manual 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 an 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) Day TX must be billed as a bundled service and includes the following:

(a) CBPRS; and

(b) group therapy.

(5) It is not required that each member receiving Day TX receive every service listed above. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

(6) Day Treatment is limited to 3 hours per day unless granted an exception by the department.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br>**Treatment Bureau**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*440* | **Subject:**<br>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 an independent living setting.

## Medical Necessity Criteria

The member must meet the Severe and Disabling Mental Illness (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.

## Provider Requirements

AFC must be provided by a licensed MHC with a Medicaid therapeutic foster care endorsement.

## 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) AFC must be billed as a bundled service and includes the following:

(a) clinical assessment; and

(b) crisis services.

(4) It is not required that each member receiving AFC receive every service listed above. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

(5) 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.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review is not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>*New* |
| **Policy Number:**<br>*445* | **Subject:**<br>Behavioral Health Group Home (BHGH) |

## Definition

A BHGH provides short-term supervision, stabilization, treatment, and behavioral modification in order for the member to be able to reside outside of a structured setting. Trained staff members are present 24/7 to provide care and assistance with daily needs like medication, daily living skills, meals, paying bills, transportation and treatment management.

## Medical Necessity Criteria

(1) The member must meet the Severe and Disabling Mental Illness (SDMI) criteria, as described in this manual;

(2) The member meets the Level of Impairment for this level of care; and

(3) The member requires the provision of service for BHGH level of care.

## Provider Requirements

(1) A provider of BHGH must be a licensed MHC with an endorsement to provide group home services.

(2) BHGHs must have the following full-time equivalency (FTE) staff:

(a) Program Supervision, .5 FTE;
Provides clinical oversight to the treatment team within the group home, conducts and supervises the treatment plan, and provides clinical treatment to the member as medically necessary. This position will have knowledge of each member in the house and will have contact with each member a minimum of once per week.

(b) Residential Manager, 1 FTE;

- Coordinate and manage the operation of group homes and supervise staff.
- Provide training and supervision to staff in accordance with state and federal regulations.
- Participate as part of an interdisciplinary team in the development and implementation of each member's individual treatment plans.
- Maintain staff schedule according to staffing limitations.
- Seek input and maintain effective communication with clinical program supervisor.
- Plan and participate directly in recreational, therapeutic, and training activities of the members.
- Provide on-call services and respond to house needs.
- Comply with all standards to assure the health and safety of member and staff.
- Must report any suspected abuse, neglect or exploitation to the department.

(c) Care Coordinator, 1 FTE;

(d) 24-hour awake staff; and

(e) Peer Support, .5 FTE

## Service Requirements

(1) BHGH must be billed as a bundled rate and includes the following:

(a) residential services for supervision and safety, 24-hours a day;

(b) behavioral modification and management that assists the member with:

- identifying the member needs for independent living within the community;
- learning to put what the member identifies into practice; and
- preparing the member to live independently in the community outside of a structured setting.

(2) BHGHs must complete the following documentation for all services billed, as described in the AMDD Medicaid Provider Manual:

(a) an annual clinical assessment;

(b) a social determinants of health assessment upon admission and annually for each member who is authorized to receive services for more than 365 days;

(c) an individualized treatment plan;

(d) a Serious and Disabling Mental Illness and Level of Impairment worksheet upon admission and updated with each treatment plan update; and

(e) a progress note for each shift.

(3) Members receiving BHGH may choose to receive Day Treatment services concurrently with BHGH.

## Utilization Management

(1) Prior authorization is required.

(2) Continued stay reviews are required every 60 days.

(3) If a member requires services beyond 120 days, the member must be referred for screening and evaluation for the SDMI, Home and Community Based Services(HCBS) waiver. If the member does not qualify for the SDMI HCBS waiver, the provider may request additional continued stay reviews as directed in (2) of this section.

(4) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*450* | **Subject:**<br>Crisis Stabilization Program |

## Definition

Crisis Stabilization Program is short-term emergency treatment for crisis intervention and stabilization. It is a residential alternative 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.

(1) "Inpatient crisis stabilization facility" means 24-hour supervised residential treatment of fewer than 16 beds for adults with a mental illness for the purpose of stabilizing the member's symptoms.

(2) "Outpatient crisis stabilization facility" means an outpatient program operated by a licensed hospital or a licensed mental health center that provides evaluation, intervention, and referral for individuals experiencing a crisis due to mental illness or a mental illness with a co-occurring substance use disorder for no more than 23 hours and 59 minutes from the time the member arrives at the program.

## Medical Necessity Criteria

Any mental health diagnosis from the current version of the DSM or ICD diagnosis 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 ongoing 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 an inability 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 member'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 licensed clinical mental health professional, being significantly above the member'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 functioning 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, or;

(e) a licensed clinical mental health professional'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.

## Provider Requirements

Crisis Stabilization Program must be provided by a licensed hospital or licensed MHC and must be approved by the department.

## Service Requirements

(1) Crisis Stabilization Program must be billed as a bundled service and includes the following:

(a) 24-hour awake direct care staff;

(b) 24-hour on call licensed clinical mental health professional;

(c) crisis stabilization services;

(d) psychotropic medications administered and monitoring behavior during the crisis stabilization period;

(e) observation of symptoms and behaviors;

(f) case management services;

(g) support or training for self-management of psychiatric symptoms; and

(h) individual, family, or group psychotherapy.

(2) It is not required that each member receiving the Crisis Stabilization Program bundle receive every service listed above. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

## Utilization Management

(1) Prior authorization is not required. Admission to Crisis Stabilization Program requires documentation in the member's file of a current DSM or ICD 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.

(2) Continued stay reviews are required for more than eight days in the Crisis Stabilization Program, and will be required every three days thereafter, and may be submitted via Auto-Authorization (Policy 206/206a).

(3) Inpatient crisis stabilization facility must show the following:

(a) Any mental health diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis and all the following:

(i) active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria; and

(ii) a lower level of care is inadequate to meet the member's treatment or safety needs.

(b) In addition to (1) above, either (a), (b), or (c) below:

(i) there is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the inpatient setting;

(ii) there is a high likelihood of either risk to the member's safety, clinical well-being, or further significant acute deterioration in the member's condition without continued care and lower levels of care are inadequate to meet these needs; or

(iii) the appearance of new impairments meeting admission guidelines.

(4) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>*New* |
| **Policy Number:**<br>*455* | **Subject:**<br>Montana Assertive Community Treatment (MACT) |

## Definition

MACT is intended to provide medication and community support for members who require long-term, ongoing support to be maintained successfully in the community and remain out of higher levels of care for members who can successfully reside outside of a structured setting.

## Medical Necessity Criteria

(1) The member must meet the SDMI criteria; and
(2) The member must need PACT services as described in the Substance Abuse and Mental Health Services Administration, Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT, Training Frontline Staff, Module 1 at: https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344.

## Provider Requirements

(1) -MACT may be provided by a licensed MHC by a –MACT team that has been approved by the department to provide –MACT.

(2) For department approval, the provider must submit a request for –MACT approval to the Addictive and Mental Disorders Division. The department will not approve a –MACT team where there is not demonstrated need for services.

(3) Each –MACT team may provide services for up to 50 members.

(4) MACT teams must consist of the following full-time equivalency (FTE) staff as described in the Community Maintenance Program – Standalone Staff Roster Outline:

(a) Prescriber, .375 FTE;

(b) Physician/Psychiatrist Supervision; two hours per month;

(c) Team Lead, one FTE;

(d) Nursing staff, one FTE;

(e) Professional staff, one FTE;

(f) Care Coordinators, one FTE;

(g) Paraprofessionals, one FTE;

(h) Certified Peer Support Specialists, two FTE; and

(i) Administrative Assistant, 1 FTE.

(7) MACT teams must submit a staffing roster to the department when there is a change in the team staff within 14 days of the change.

(8) Provider may request staffing waivers of up to 90 days to fill vacant positions. If the position cannot be filled within 90 days, the provider must bill for services fee for service until such time the team has been brought whole.

(9) Providers must submit a MACT monthly report and other PACT quality measures at a frequency established in the PACT Quality Measures guidelines.

(10) MACT must be billed as the appropriate bundled service.

## Service Requirements

(1) The provision of MACT services must comply with the fidelity standards of Assertive Community Treatment, as modified for the intensity of this service, as demonstrated by PACT fidelity reviews. MACT programs that fail to comply with Assertive Community Treatment fidelity standards are subject to correct action, remediation, and possible suspension of the MACT program.

(2) MACT bundled service includes:

(a) monitoring all of member's health care needs including social determinants of health;

(b) providing intensive treatment and rehabilitative services to aid the member in recovery and reduce disability;

(c) identifying, restoring, and maintaining the member's functional level to their best possible functioning level;

(d) identifying, improving, and sustaining social determinants of health; and

(e) providing individualized crisis planning and 24-hour, seven days a week face-to-face crisis intervention.

(3) It is not required that each member receiving MACT receive every service. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

(4) MACT teams must complete the following documentation for each member receiving MACT:

(a) an annual clinical assessment that follows the guidelines in the AMDD Medicaid Provider Manual;

(b) a social determinants of health assessment upon admission and annually for each member who is authorized to receive services for more than 365 days;

(c) an individualized treatment plan that is updated every 90 days or when there is a change to the member's strengths, areas of concern, goals, objectives, or interventions;

(d) a Serious and Disabling Mental Illness and Level of Impairment worksheet upon admission and updated with each treatment plan update; and

(e) a progress note for each service provided as required in ARM 37.85.414.

(f) MACT teams must meet and discuss the status of their members five days per week and complete a staff meeting log for each member which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's status.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are required every 180 days.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>*New* |
| **Policy Number:**<br>*460* | **Subject:**<br>Program for Assertive Community Treatment (PACT) – Tiered System |

## 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 service delivery is provided by a multi-disciplinary, self-contained clinical team, 24 hours a day, 7 days a week, 365 days a year.

PACT is the core service of a tiered PACT delivery system which includes the following three tiers:

- Intensive PACT (InPACT);
- PACT; and
- Community Maintenance Program (CMP).

InPACT is an intensive transitional PACT service within a residential setting for members who need short-term supervision, stabilization, treatment, and behavior modification in order for a member to be able to reside outside of a structured setting.

CMP is intended to provide medication and community support for members who require long-term, ongoing support at a higher level than traditional outpatient services to be maintained successfully in the community and remain out of higher levels of care.

## Medical Necessity Criteria

**For all three PACT Tiers:**

- The member must meet the SDMI criteria, as described in this manual;
- The member must need PACT services as described in the Substance Abuse and Mental Health Services Administration, Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT, Training Frontline Staff, Module 1 at:

https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344.

**Additional Medical Necessity Criteria for each tier is below.**

**Medical Necessity for InPACT:**

- The member requires daily clinical support and direct care in order to address the needs of the member;
  **AND**
- The member is discharging from Montana State Hospital or the Montana Mental Health Nursing Care Center;
  **OR**
- The member is at serious risk of involuntary hospitalization (recently provided services at a behavioral health unit or a crisis stabilization home).

**Medical Necessity for PACT:**

- The member requires contact at least three days per week.

**Medical Necessity for CMP:**

- The member requires at least two contacts per month.

## Provider Requirements

(1) PACT tiers may be provided by a licensed MHC by a PACT team that has been approved by the department to provide PACT services.

(2) For department approval, the provider must submit a request for PACT team approval to the Addictive and Mental Disorders Division. The department will not approve a PACT team where there is not demonstrated need for services.

(3) Each PACT team may provide services for up to 196 members when providing all three PACT tiers described above.

(4) The following ratios apply per PACT team providing all three PACT tiers:

(a) up to 80 total members per PACT team receiving the core PACT tier;

(b) up to 16 total members per PACT team receiving InPACT; and

(c) up to 100 total member per PACT team receiving CMP.

(5) PACT teams not providing InPACT may provide:

(a) PACT core services for up to 96 members; and

(b) CMP up to 100 members.

(6) Members who are receiving InPACT may reside in a Behavioral Health Group Home (BHGH). Providers must bill for the service being provided and may not bill for both InPACT and BHGH concurrently. The provider must meet the licensure requirements for the service

being billed. The member receiving services in InPACT must be provided services from the PACT team. PACT team members are dedicated staff; therefore, the clinical, care management, and certified behavioral peer support components in the BHGH cannot replace services of the PACT team nor can the PACT team provide services to members who are not admitted into the PACT program.

(7) PACT Teams must consist of the following full-time equivalency (FTE) staff, effective October 1, 2020, as described in the Program of Assertive Treatment Staff Roster Outline:

(a) Prescriber, one FTE;

(b) Physician/Psychiatrist Supervision; two hours per month;

(c) Team Lead, one FTE;

(d) Nursing staff, two FTE;

(e) Professional staff, two FTE;

(f) Care Coordinators, three FTE;

(g) Paraprofessionals, two FTE;

(h) Licensed Addiction Counselor, one FTE;

(i) Vocational Specialist, one FTE;

(j) Certified Peer Support Specialists, two FTE;

(k) Administrative Assistant, two FTE; and

(l) Tenancy Specialist, one FTE.

(8) PACT teams must submit a staffing roster to the department when there is a change in the team staff within 14 days of the change.

(9) Provider may request staffing waivers of up to 90 days to fill vacant positions. If the position cannot be filled within 90 days, the provider must bill for services fee for service until such time the team has been brought whole.

(10) Providers must submit a PACT monthly report and other PACT quality measures at a frequency established in the PACT Quality Measures guidelines.

(11) PACT must be billed as the appropriate bundled service based upon the PACT tier being provided.

## Service Requirements - All three PACT Tiers

(1) The provision of PACT services must comply with the fidelity standards of Assertive Community Treatment as demonstrated by PACT fidelity reviews. PACT programs that fail to comply with PACT fidelity standards are subject to corrective action, remediation, and possible suspension of the PACT program.

(2) PACT teams must provide the following services, as identified in each member's individualized treatment plan:

(a) monitoring all of the member's health care needs including social determinants of health;

(b) providing intensive treatment and rehabilitative services to aid the member in recovery and reduce disability;

(c) identifying, restoring, and maintaining the member's functional level to their best possible functioning level;

(d) identify, improve, and sustain social determinants of health; and

(e) provide individualized crisis planning and 24-hour, seven days a week face-to-face crisis intervention; and

(f) Residential services for InPACT include behavior modification and management, assisting the member with identifying what they need for independent living within the community, putting what they identify into practice, and preparing the member to live independently in the community outside of a structured setting.

(3) PACT teams must complete the following documentation for each member receiving PACT tiered services:

(a) an annual clinical assessment that follows the guidelines in the AMDD Medicaid Provider Manual;

(b) a social determinants of health assessment upon admission and annually for each member who is authorized to receive services for more than 365 days;

(c) an individualized treatment plan that is updated every 90 days or when there is a change to the member's strengths, areas of concern, goals, objectives, or interventions;

(d) a Serious and Disabling Mental Illness and Level of Impairment worksheet upon admission and updated with each treatment plan update; and

(e) a progress note for each service provided as required in ARM 37.85.414.

**Additional Service Requirements for each PACT tier is below.**

It is not required that each member receiving a PACT tier receive every service listed below. Medically necessary services that are billed must be documented clearly in the member's individualized treatment plan in the member's file.

**Service Requirements for PACT**

(1) The PACT service bundle includes the following:

(a) medication management;

(b) medication administration, delivery, and monitoring;

(c) care coordination;

(d) 24-hour crisis response;

(e) psychosocial rehabilitation;

(f) vocational rehabilitation;

(g) substance use disorder treatment;

(h) individual, family, and group therapy, and;

(i) peer support.

(2) PACT teams must meet and discuss the status of their members five days per week. PACT teams must complete a staff meeting log for each member in the core PACT service three days per week which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's status.

**Service Requirements for InPACT**

(1) The PACT service bundle above in a residential setting.

(2) PACT teams must meet and discuss the status of their members five days per week. PACT teams must complete a staff meeting log for each member in InPACT five days per week which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's staus.

**Service Requirements for CMP**

(1) The CMP as part of the PACT tier includes:

(a) medication management;

(b) medication administration, delivery, and monitoring;

(c) 24-hour crisis response;

(d) care coordination;

(e) psychosocial rehabilitation; and

(f) peer support.

(2) PACT teams providing CMP must meet and discuss the status of their members two days per month. PACT teams must complete a staff meeting log for each member which includes:

(a) date and time of meeting;

(b) staff present;

(c) member's name discussed;

(d) services provided in the past 24 hours; and

(e) member's staus.

## Utilization Management

**Utilization Management for PACT**

(1) Prior authorization is not required.

(2) Continued stay reviews are required every 180 days.

**Utilization Management for InPACT**

(1) Prior authorization is required and may be approved for up to 60 days.

(2) Continued stay reviews are required every 60 days.

(3) If a member requires services beyond 120 days, the member must be referred for screening and evaluation for the Severe and Disabling Mental Illness(SDMI), Home and Community Based Services(HCBS) waiver. If the member does not qualify for the SDMI HCBS waiver, the provider may request additional continued stay reviews as directed in (2) of this section.

**Utilization Management for CMP**

(1) Prior authorization is not required.

(2) Continued stay reviews are required every 365 days.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*465* | **Subject:**<br>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.

## Medical Necessity Criteria

(1) The member must meet the SDMI criteria as described in this manual including all of the following:

(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 decompensation.

## 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.

## 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 or psychiatrist;

(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) Acute PHP must be billed as a bundled service and includes the following:

(a) all outpatient psychiatric and psychological treatments and services;

(b) laboratory and imaging services;

(c) drugs;

(d) biologicals;

(e) supplies;

(f) equipment;

(g) therapies;

(h) licensed nurses (LPN/RN);

(i) licensed clinical social workers;

(j) licensed clinical psychologists;

(k) licensed clinical professional counselors; and

(l) other outpatient services, that are part of or incident to the partial hospitalization program, except as provided in the department's Medicaid Mental Health Fee Schedule.

(3) It is not required that each member receiving the PHP bundle receive every service listed above. Medically necessary services must be provided and documented in the treatment plan and the services received must be documented clearly in the member's file.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay reviews are not required

(3) The member must continue 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.

(4) The provider must document in the file of the member every 90 days that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*470* | **Subject:**<br>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.

## Medical Necessity Criteria

(1) Any mental health diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis; and

(2) The member is a danger to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

## 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 a utilization review plan in effect 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.

## Service Requirements

Acute Inpatient Hospital services must be provided in accordance with all state and federal regulations pertaining to the administration of the service. All Medicaid-eligible members

transitioning to the community, can receive targeted case management services during the last 180 consecutive days of a Medicaid-eligible member's inpatient hospital stay.

## Utilization Management

(1) Prior authorization Criteria:
   (a) Prior Authorization is not required for in-state acute inpatient hospital.
   (b) Prior authorization is required for OOS facilities and may be submitted via Auto-Authorization (Policy 206/206a).
   (c) The department or the UR Contractor may issue the prior authorization for as many days as deemed medically necessary up to 60 days.

(2) Continued Stay Review Criteria:

   (a) Any mental health diagnosis from the current version of the DSM or ICD as the primary diagnosis;

   (b) Active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria and that still exist;

   (c) A lower level of care is inadequate to meet the member's needs regarding either treatment or safety; and

   (d) 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.

   (e) For OOS facilities, the department or the UR Contractor may issue the continued stay authorization for as many days as deemed medically necessary.

(3) Montana Medicaid Adult Certificate of Need:

   (a) 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.

   (b) 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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*505* | **Subject:**<br>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 or being treated for a substance use disorder. As such, it is a part of medical care.

## Medical Necessity Criteria

The member must meet the SUD criteria found in this manual. Drug testing must be based on patient-specific elements identified during the clinical assessment and documented by the clinician.

## Provider Requirements

Drug testing must be provided by a state-approved substance use disorder program. Drug testing is not a bundled service and must be billed using the appropriate CPT codes.

## Service Requirements

(1) Drug tests are limited to one test per 24-hour period per member; and

(2) The need for drug testing services must be written into the ITP~~;~~

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*510* | **Subject:**<br>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.

## 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.

## Provider Requirements

(1) SUD TCM must be provided by a state-approved substance use disorder program in order to bill Montana Medicaid.

(2) SUD TCM services cannot be used for activities that are the responsibility of other systems.

(3) SUD TCM is not a bundled service and must be billed using the appropriate HCPCS code.

## 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, go to the most current version of the Montana Medicaid provider notice at http://medicaidprovider.mt.gov/.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*515* | **Subject:**<br>SUD Certified Behavioral Health Peer Support Services (CBHPSS) Adult |

## Definition

BHPS is a face-to-face service provided one-to-one to promote positive coping skills through mentoring and other activities that assist a member with a SUD diagnosis to achieve their goals for personal wellness and recovery. The purpose is to help members through a process of change to improve their health and wellness, live a self-directed life, and strive to reach their full potential.

## Medical Necessity Criteria

Member must meet the SUD criteria as described in this manual.

## Provider Requirements

(1) In order to bill Montana Medicaid, BHPS must be provided by a Certified Behavioral Health Peer Support Specialist (CBHPSS), certified by the Montana Board of Behavioral Health (BBH) and provided by a state-approved program, Federally Qualified Health Center, Rural Health Clinic, Urban Indian Health Center, or IHS Tribal 638.

(2) The state-approved program must:

(a) ensure staff are certified by the BBH;

(b) develop policies and procedures for initial and on-going staff training for these services;

(c) assure ongoing communication and coordination of the treatment team to ensure the services provided are updated as needed; and

(d) establish the frequency of services as determined by needs and desires of the member.

## Service Requirements

(1) BHPS must be a direct service provided in an individual setting.

(2) Group peer support is not a Medicaid reimbursable service.

(3) Transportation of a member in and of itself does not constitute an allowable direct service.

(4) The ITP must include peer support goals that address the member's primary behavioral health needs.

(5) Individual BHPS is not a bundled service and must be billed using the appropriate HCPCS code.

(6) BHPS includes the following:

(a) coaching to restore skills;

(b) self-advocacy support;

(c) crisis/relapse support;

(d) facilitating the use of community resources; and

(e) restoring and facilitating natural supports and socialization.

(7) It is not required that each member receiving BHPS receive every service listed above. Medically necessary services must be provided and documented in the individualized treatment plan and the services received must be documented clearly in the member's treatment file.

(8) BHPS services must be delivered by a dedicated BHPS whose primary responsibility is the delivery of BHPS services.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*520* | **Subject:**<br>SUD Outpatient (OP) Therapy (ASAM 1.0) Adult and Adolescent |

## Definition

SUD OP therapy services include recovery or motivational enhancement therapies/ strategies. Services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided. ASAM 1.0 is defined as less than nine hours of service a week (adults) and less than six hours per week (adolescent).

## 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.

## 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) SUD OP is not a bundled service and must be billed using the appropriate outpatient therapy codes.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*525* | **Subject:**<br>SUD Intensive Outpatient (IOP) Services (ASAM 2.1) Adult and Adolescent |

## Definition

IOP programs provide nine or more hours of structured programming per week (adults) or six or more hours per week (adolescents) to treat multidimensional instability.

## Medical Necessity Criteria

(1) The member must have a moderate or severe SUD diagnosis from the current version of the DSM or ICD diagnosis as the primary diagnosis and meet the ASAM criteria for diagnostic and dimensional admission criteria for ASAM 2.1 level of care.

(2) The member requires three or more core services as described below.

## Provider Requirements

State-approved programs who choose to provide IOP must bill the IOP bundled rate unless they are providing fewer than the number of hours specified in the service requirements below.

Professionals with the appropriate licensure and credentials who choose to provide IOP must bill with the appropriate outpatient codes.

## Service Requirements (All IOP services)

(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) therapies;

(b) support systems;

(c) assessment/ITP review;

(d) staff; and

(e) documentation.

(4) Professionals with the appropriate licensure and credentials who choose to provide IOP and state-approved programs providing fewer than the number of hours specified in the service requirements below must bill the appropriate outpatient codes.

## Service Requirements (IOP bundled services ONLY)

(1) IOP may be billed as a bundled service only by state-approved substance use disorder programs and when billing this way, the service bundle includes the following core services:

(a) individual SUD therapy;

(b) group SUD therapy;

(c) family SUD therapy;

(d) educational groups;

(e) psychosocial rehabilitation;

(f) co-occurring mental health treatment;

(g) crisis services (face to face); and

(h) care coordination (face to face).

(2) It is not required that each member receiving the ASAM 2.1 bundle receive every service listed above. Medically necessary services must be provided and documented in the individualized treatment plan and the services received must be documented clearly in the member's treatment file.

(3) Provider must be available for 24/7 crisis coverage.

(4) Provider must offer drug testing as a therapeutic tool if indicated as clinically appropriate in the member's ITP.

(5) IOP provided as part of the bundled services must include the following: (a) Member must receive 3 or more different core services per week;

(b) One core service each week must be a skilled treatment service as defined in the ASAM Criteria; and

(c) A billable day must be a minimum of 45 minutes of face-to-face services;

(6) Core services must be provided face-to-face.

(7) Core services must be provided by a state approved program or through contract/agreement with other entities.

(8) The provider must include discharge planning in the Member's ITP.

(9) If a provider is billing the High Tier bundled rate, the member must receive a minimum 6 hours (adult) and 4 hours (adolescent) of programming per week for IOP-High Tier;

(10) If a provider is billing the Low Tier bundled rate, the member must receive between 4 to 5 hours (adult) of programming per week for IOP-Low Tier;

(11) Providers billing the bundled rate for IOP must complete the DLA-20 for members upon admission in to and discharge from the service.

(12) Providers must submit to Montana Medicaid on a quarterly basis the services provided to each member each week during the program as well as the results of the DLA-20.

(13) State-approved providers may bill applicable outpatient codes for the service components provided instead of billing the bundled rates. Providers may not bill both a bundled rate AND applicable outpatient codes for any of the core services described in the definition.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review is required for the IOP bundle after first 60 billable days for up to 15 billable days. Continued stay review is NOT required if the provider is not billing the IOP bundled rate.

(3) Member must continue to meet the SUD criteria as described in this manual and meet the ASAM criteria diagnostic and dimensional admission criteria for SUD IOP Services (ASAM 2.1) Adult and Adolescent level of care.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*530* | **Subject:**<br>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. ASAM 2.5 is provided in a setting that complies with licensure rule and has direct access to psychiatric, medical, and laboratory services on site.

## 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.

## Provider Requirements

ASAM 2.5 must be provided by a state-approved substance use disorder program.

## 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) therapies;

(b) support systems;

(c) assessment/ITP review;

(d) staff; and

(e) documentation.

(3) ASAM 2.5 is billed as a bundled service and includes the following:

(a) individual SUD therapy;

(b) group SUD therapy;

(d) family SUD therapy; and

(e) psychosocial rehabilitation.

(4) It is not required that each member receiving the ASAM 2.5 bundle receive every service listed above. Medically necessary services must be provided and documented in the *individualized* treatment plan and the services received must be documented clearly in the member's treatment file.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

(3) Member must continue to meet the SUD criteria as described in this manual and meet the ASAM criteria diagnostic and dimensional admission criteria SUD Partial Hospitalization (ASAM 2.5) Adult and Adolescent level of care.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*535* | **Subject:**<br>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. ASAM 3.1 includes a minimum of 5 hours per week of professionally directed treatment services.

## Medical Necessity Criteria

Member must meet the moderate or severe 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.

## Provider Requirements

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

## 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) therapies;

(b) support systems;

(c) assessment/ITP review;

(d) staff; and

(e) documentation.

(3) Clinical therapy hours provided in ASAM 3.1 are reimbursable through Medicaid for members who are Medicaid eligible and may be billed using:

(a) the appropriate outpatient codes for the therapeutic services provided; or

(b) the Intensive Outpatient (IOP) Service bundled rate if provided by state-approved substance use disorder programs. State-approved substance use disorder providers must avoid duplicate billing when billing the IOP bundled rate.

(4) Room and board for the member's stay is a non-Medicaid service and is reimbursable through contract with AMDD.

## Utilization Management

(1) 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.

(2) Continued stay review is required for up to 30 days.

(3) 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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*540* | **Subject:**<br>SUD Clinically Managed High-Intensity Residential (ASAM 3.5) Adult<br>SUD Clinically Managed Medium-Intensity Residential (ASAM 3.5) Adolescent |

## Definition

ASAM 3.5 is clinically managed residential treatment programs providing 24-hour structured residential treatment. Members are provided a planned regimen of 24-hour professionally directed SUD treatment. These services are provided to members diagnosed with a moderate or severe SUD and whose substance related problems are so significant they require 24-hour supported treatment environment. Services focus on stabilizing the member to transition into a less intensive level of care or community setting. Programs are staffed by Licensed Addictions Counselors and behavioral health staff. There is access to medical staff.

## Medical Necessity Criteria

Member must meet the moderate or severe 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.

## Provider Requirements

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

## 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) therapies;

(b) support systems;

(c) assessment/ITP review;

(d) staff; and

(e) documentation.

(3) ASAM 3.5 is an inclusive bundled service that is comprised of the following:

(a) individual SUD therapy;

(b) group SUD therapy;

(c) family SUD therapy; and

(d) psychosocial rehabilitation.

(4) It is not required that each member receiving the ASAM 3.5 bundle receive every service listed above. Medically necessary services must be provided and documented in the individualized treatment plan and the services received must be documented clearly in the member's treatment file.

## Utilization Management

(1) 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.

(2) Continued Stay Review is required for up to five days.

(3) 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.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*545* | **Subject:**<br>SUD Medically Monitored Intensive Inpatient (ASAM 3.7) Adult<br>SUD Medically Monitored High Intensity Inpatient (ASAM 3.7) Adolescent |

## Definition

ASAM 3.7 is medically monitored inpatient treatment services. 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 moderate or severe 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. Programs are staffed by physicians, nurses, Licensed Addictions Counselors, and behavioral health staff.

## Medical Necessity Criteria

Member must meet the moderate or severe 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.

## Provider Requirements

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

## 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) therapies;

(b) support systems;

(c) assessment/ITP review;

(d) staff; and

(e) documentation.

(3) ASAM 3.7 is an inclusive bundled service that is comprised of the following:

(a) individual SUD therapy;

(b) group SUD therapy;

(c) family SUD therapy;

(d) nurse intervention and monitoring; and

(e) psychosocial rehabilitation.

(4) It is not required that each member receiving the ASAM 3.7 bundle receive every service listed above. Medically necessary services must be provided and documented in the individualized treatment plan and the services received must be documented clearly in the member's treatment file.

## Utilization Management

(1) Prior authorization is required and may be submitted via Auto-Authorization (Policy 206/206a).

For manual authorizations the following applies:

The initial three days are automatically authorized. The ASAM 3.7 prior authorization form must be submitted within three calendar days of admission.

(2) Continued stay review is required after the first three days of service.

(a) 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.

(b) Results of the initial lab results at admission will be required for the continued stay review.

| | |
|---|---|
| MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services | **Addictive and Mental Disorders Division**<br><br>Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health |
| | **Date effective:**<br>July 1, 2020<br><br>**Date revised:**<br>July 1, 2020 |
| **Policy Number:**<br>*550* | **Subject:**<br>Medication Assisted Treatment (MAT) |

## Definition

MAT is the use of medications approved by the US Food and Drug Administration (FDA), in combination with behavioral therapies and support services, to provide a whole-patient, patient-centered approach to the treatment of alcohol and opioid use disorders. These rules pertain to the following MAT providers:

(1) Opioid Treatment Program (OTP), is an accredited treatment program with SAMHSA certification and Drug Enforcement Administration (DEA) registration to administer and dispense opioid agonist medications, including Methadone, that are approved by the FDA to treat opioid addiction. OTPs must provide medical, counseling, vocational, educational, and other assessment and treatment services, either onsite or by referral to an outside agency or practitioner through a formal agreement, as identified in the members ITP; or

(2) Office-based Opioid Treatment (OBOT), which is an organization that employs or contracts with a provider who holds a current waiver with SAMHSA and has been assigned a DEA identification number for buprenorphine prescribing for opioid use disorders. OBOTs may only provide buprenorphine opioid treatment. OBOTs must provide medical, counseling, vocational, educational, and other assessment and treatment services, either onsite, or by referral to an outside agency or practitioner through a formal agreement, as identified in the member's ITP.

## Medical Necessity Criteria

(1) Member must:

(a) have a diagnosed moderate or severe opioid use disorder;

(b) be determined clinically appropriate for MAT; and

(c) agree to initiate MAT and receive other services identified in the ITP.

(2) The member must require at least one face to face or by telemedicine check-in per month for dispensing of medication.

(3) The member must have at least one of the following:

(a) significant psychological or social challenges;

(b) failure to successfully initiate treatment in previous attempt; or

(c) lack of solid social supports.

## Provider Requirements

Providers are expected to follow federal regulations in the provision of all Medication Assisted Treatment (MAT) services.

(1) Members must be assessed at intake for the MAT program by a Medicaid approved provider who meets the requirements listed below.

(2) The following MAT services are bundled services and must be billed using the appropriate reimbursement codes for:

(a) MAT Intake; and

(b) MAT Established.

(3) MAT Intake may only be reimbursed for the first week of the members enrollment into the MAT program, and no more than once every 30 days if the member has discharged from the program and is re-enrolling.

(4) MAT Intake includes:

(a) a face to face assessment by a physician or mid-level practitioner;

(b) substance use disorder assessment;

(c) mental health assessment or screening and referral, if appropriate;

(d) tobacco screening (if clinically appropriate);

(e) screening for alcohol misuse / abuse (AUDIT/CRAFFT);

(f) presumptive drug screening;

(g) urine pregnancy test (if clinically appropriate); and

(h) induction of medication.

(5) MAT Established, which may be reimbursed beginning week two and weekly thereafter, as clinically indicated, must include the following:

(a) one visit with a physician or mid-level provider, face to face or by telemedicine, per month;

(b) member check-in, at the clinic, the members home, or via telemedicine, a minimum of once a week;

(c) monthly pregnancy test for HCG, when clinically appropriate;

(d) monthly presumptive drug testing; and

(e) update of the ITP every 30 days.

(6) Medication and labs, as clinically appropriate, that are not included within the bundled rate may be reimbursed outside of the bundled rates.

(7) Clinically appropriate screening and laboratory services associated with the provision of MAT may not be billed more than once per month, fee for service, for the member who:

(a) is being assessed for enrollment into the MAT program as described in (2);

(b) is enrolled in the MAT program as described in (4) and (5); or

(c) has completed the MAT program is but is still receiving MAT services via fee for service.

(8) Montana Healthcare Programs do not authorize payment of opioids, Tramadol, or Carisoprodol when members are utilizing the services of a Medication Assisted Treatment (MAT) provider, or after treatment with MAT administered Methadone, or outpatient prescription Buprenorphine-containing products has begun. If a member subsequently discontinues MAT, and/or the Buprenorphine-containing product, all opioids, Tramadol formulations, and Carisoprodol will remain as non-covered for the member. These medications will require prior authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis only after the case is reviewed with the treating provider and the provider prescribing the Buprenorphine-containing product or providing the Methadone treatment.

## Service Requirements

(1) A MAT provider must present the member with the following information as evidenced by signature of the member:

(a) all relevant facts concerning the use of MAT that is clearly and adequately explained;

(b) other treatment options and detoxification rights;

(c) a written estimate of expenditure including the amount expected to be covered by insurance and/or other payment sources and out of pocket expenditures for the member;

(d) written program participation expectations and a list of incidents that require termination of program participation;

(e) written procedures for non-compliance and discharge including administrative medication withdrawal; and

(f) education pertaining to their prescription.

(2) The provider must review the Montana Prescription Drug Registry for the member's past and current use of Category II and III prescriptions prior to the induction of MAT.

(3) The provider must employ or have a written agreement on file for SUD counseling services provided by:

(a) a licensed addiction counselor; or

(b) a licensed mental health professional with SUD within their scope of practice.

(4) The provider must offer behavioral health counseling services to the member, if clinically appropriate, and document it in the ITP;

(5) Services must be based on a physical, exam, screening, and assessment described above and documented in the member's ITP.

(6) If a member meets the requirements for high risk pregnancy as described in ARM 37.86.3402, prenatal care must be included in the member's ITP.

(7) An initial ITP must be completed within seven days of enrollment into MAT, updated every 30 days, and include the following medication addiction treatment services:

(a) medication prescribing and adjustment by prescribing professional;

(b) nursing assessment of medication tolerance and vital signs;

(c) lab test outcomes and compliance with MAT;

(d) medication distribution;

(e) plans for behavioral health services;

(f) care coordination services to address identified medical, social, SUD, and mental health issues; and

(g) signature of the member and the staff who prepared the ITP.

(8) The provider must complete and submit the Montana Healthcare Programs Medication Assisted Treatment Member Form as directed on the form for all new members utilizing MAT services, and all members discharging from MAT services, within 7 days of enrollment or termination of services, located at: https://medicaidprovider.mt.gov/forms#240933960-forms-m--o.

(9) The provider must refer to the Montana Prescription Drug Registry to determine if the member is receiving an opioid or tramadol prescription concurrently with MAT services.

(10) The provider must notify the member that they will be locked out of opioid prescriptions, once enrolled in a MAT program, unless a prior authorization is granted for a specified episode of care.

(11) Telemedicine must be provided in accordance with applicable federal and state laws and policies and follow the Controlled Substances Act (CSA)(28 USC 802) for prescribing and administration of controlled substances.

## Utilization Management

(1) Prior authorization is not required.

(2) Continued stay review not required.

(3) The provider must document in the file of the member that he or she meets the medical necessity criteria.