Clinical Policy: In Lieu of Services

Reference Number: NC.CP.MP.503
Date of Last Revision: 02/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

In Lieu of Services (ILOS)- Such services or settings that the State, in accordance with 42 CFR 438.3(e)(2), determines to be alternative services or settings that are medically appropriate and cost-effective substitutes for a covered service or setting under the Medicaid State plan.
In Lieu of Services (ILOS) is an affordable alternative to a covered service and may help members avoid costly behavioral health treatments such as inpatient hospital stays and emergency department visits.

Policy/Criteria

I. In accordance with the North Carolina Medicaid contract section *cc. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, g.* - In Lieu of Service, the PHP may use In Lieu of Services (ILOS), or settings that are not covered under the North Carolina Medicaid State Plan.

II. It is the policy of Carolina Complete Health that the following In Lieu of Services meet criteria for coverage as follows:

A. **Institutes for Mental Disease (IMD)**

1. **Service Definition**: The PHP may contract and pay for services for members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in another covered setting for no more than fifteen (15) calendar days within a calendar month.
2. **Purpose**: Service allows eligible members to have their mental health and substance use disorder inpatient treatment needs addressed within or closer to their home community increasing the likelihood of engaging paid and natural supports throughout the treatment process. Medical, surgical, and hospital emergency departments (ED) will also benefit by a reduction in psychiatric ED wait times when IMD providers are available to provide this service.
3. Medical Necessity Criteria (MNC) and documents requirements align with NC Medicaid Clinical Coverage Policy 8B. Service exclusions can also be found in policy 8B.

III. Mental Health Intensive Outpatient Services

A. Service Definition - Mental Health Intensive Outpatient Program means structured individual and group psychiatric activities and services that are provided at an outpatient program designed to assist adult and adolescent members to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a

day, at least 3 days a week. The Member must be in attendance for a minimum of 3 hours a day in order to bill this service.

B. Services shall include a structured program consisting of, but not limited to, the following services:
1. Individual counseling and support
2. Group counseling and support
3. Family counseling, training or support
4. Life skills
5. Crisis contingency planning
6. Treatment support activities that have been adapted or specifically designed for Member with physical disabilities, or Member with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability

Intensive outpatient treatment can be designed for homogenous groups of Member e.g., pregnant women, and women and their children; individuals with co-occurring mental health and substance use disorders; individuals with human immunodeficiency virus (HIV); or individuals with similar cognitive levels of functioning. Member may be residents of their own home, a substitute home, or a group care setting; however, the intensive outpatient treatment must be provided in a setting separate from the Member's residence. The program is provided over a period of several weeks or months. An authorization request form must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

C. **Criteria** - In order to meet medical necessity criteria for this level of care, documentation submitted by providers must demonstrate that ***InterQual Guidelines*** for admission or continued stay to an Intensive Outpatient Program are met for initial and continued stay requests.

IV. Behavioral Health Urgent Care

A. **Service Definition** - Behavioral Health Urgent Care (BHUC) is a designated service for individuals four (4) years or older experiencing a behavioral health crisis related to a substance use disorder, mental health disorder, and/or I/DD diagnosis or any combination of the above. A BHUC is designed to provide triage, crisis risk assessment, evaluation, and intervention to individuals whose crisis response needs are deemed to be urgent or emergent. A BHUC is an alternative, but not a replacement, to a community hospital Emergency Department (ED). Individuals receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care.

B. **Purpose of Service -** BHUC offers a safe alternative and diversion from the use of hospital emergency departments to address the needs of individuals experiencing behavioral health crises. A BHUC is a service containing Triage, Crisis Assessment, Interventions, Disposition and Discharge Planning.

C. **Treatment Program Philosophy, Goals and Objectives** for - Triage consists of an intensity of needs screening to be initiated within 15 minutes of arrival. During the triage process releases of information will be completed to obtain any needed information from supports and/or community providers. This screening will result in a behavioral health urgency determination status of routine, urgent or emergent and may

determine the need for emergency medical attention. Only those meeting criteria for urgent or emergent are eligible for this BHUC service. If an individual is screened and is determined to be routine, they will be referred to a community-based service provider for follow up.

1. A BHUC urgent determination status is defined in instances where the individual presents with moderate risk for incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to a MH/IDD/SU diagnosis; moderate symptoms and distress that may quickly escalate without prompt intervention; thoughts of harm to self or others, acute stressors and symptoms which may include impaired reality testing, self-care, intoxication or withdrawal.
2. A BHUC emergent determination status is defined as imminent danger to harm self or others due to symptoms of mental illness or substance use or any related medical complications; risk to self or others related to behavioral health distress; risk related to safety and supervision; severe incapacitation which may include impaired reality testing, self-care, intoxication, or withdrawal.

D. Assessment - The Crisis/Risk Assessment is designed to determine nature of crisis and risks associated with presenting concern. The Crisis/Risk assessment should be initiated within 2 hours of arrival at the BHUC. Components of the assessment can be gathered through interactions with all BHUC staff including but not limited to licensed professionals, nursing staff, and psychiatric prescribing professionals, peers, and qualified professionals (peers and QP's within their scope of practice). A licensed clinical professional is required to observe and interview the individual, establish a diagnosis, and compile an evaluation that will drive the services. The following elements must be addressed as part of the crisis assessment:

1. Description of presenting illness/problem including source of distress, precipitating events and associated problems and symptoms;
2. Demographic information;
3. Behavioral health and medical treatment history;
4. Care Coordination information;
5. Reason for referral;
6. Comprehensive Risk assessment/status;
7. Current medications;
8. Medical Screening including biometric data (vitals: pulse, blood pressure, height, and weight);
9. Current medical status and any need for emergency medical treatment;
10. Breathalyzer or urine drug screen as indicated;
11. Biopsychosocial information;
12. Mental Status Exam;
13. Level of Care Determination including ASAM level of care;
14. Establishment of a Diagnosis that will be the subject of treatment (may be Provisional or Differential Diagnosis);
15. Use of specialty assessments using validated, standardized instruments (i.e., Suicide Risk Assessment, Clinical Institute Withdrawal Assessment for Alcohol/CIWA-A rev., etc.) within the scope of practice for the individual conducting the assessment;
16. Initial disposition.

E. Disposition and Discharge Planning - Disposition and discharge planning is provided to ensure a person served through BHUC is linked to the least restrictive and most appropriate level of care. Disposition coordination and discharge planning from BHUC includes the use of person-centered strategies and processes that:

1. Provide education and information regarding community services and resources;
2. Facilitate engagement of natural supports;
3. Communicate with care management entities as needed;
4. Communicate with current community providers, including primary care and/or make referrals with written consent;
5. Provide a discharge plan that includes safety and aftercare instructions, including appointments and point of contact with contact information for agencies and medication instructions. A copy of this is to be placed in the individual's record;
6. Arrange admissions to psychiatric hospitals, Facility Based Crisis, emergency departments, or other clinically appropriate services;
7. Assistance with housing and transportation;
8. Provide education and linkage to medication assistance;
9. Develop and revise individual crisis plan;
10. If individual expresses interest, refer her/him to facilitator to develop psychiatric advance directives

V. FOR AUTHORIZATION REQUIREMENTS, please refer to Carolina Complete Health's Pre-Auth Tool and Behavioral Health Utilization Management Authorization Guidelines.

VI. Documentation Requirements, Provider Requirements, Provider Eligibility, Provider Qualifications & Occupational Licensing Entity Regulations, Provider Certifications, and Staff Training Requirements;: For additional details, please refer to North Carolina Medicaid State Policy site for ***Inpatient Behavioral Health Services Clinical Coverage Policy No: 8B*** at: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®*	Description	Billing Unit
RC0160	Institutes for Mental Disease (IMD)	1 unit=1 day

HCPCS ®*	Description	Billing Unit
S9480	Mental Health Intensive Outpatient Treatment	1 unit =1 day
T2016 U5 (without observation) T2016 U8 (with observation)	Behavioral Health Urgent Care	1 unit = 1 event

Reviews, Revisions, and Approvals	Revision Date	Approval Date
CCH-specific policy developed.		

References:

1. State of North Carolina Medicaid Clinical Coverage Policy No: 8B Inpatient Behavioral Health Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published May 1, 2025. Accessed February 2, 2026.
2. North Carolina Community Crisis Centers. Find a Community Crisis Center. Accessed February 2, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.