**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.**

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| NC Medicaid<br>Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population | Medicaid<br>Clinical Coverage Policy No: 8-I<br>Amended Date: April 1, 2023 |
|---|---|

**Related Clinical Coverage Policies**

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*

# 1.0 Description of the Procedure, Product, or Service

Psychological services for children and adolescents are goal-directed interventions designed to enable children, adolescents, and their families to cope more effectively with complex problems. Services may include comprehensive psychosocial assessments and treatment planning, goal-directed psychotherapy (individual, group, or family), and referral to other mental health resources as needed.

These services involve the identification of and intervention with children and adolescents who may be **at risk** for developing more serious emotional or behavioral problems as well as those who are already experiencing these problems. Early identification and intervention helps prevent inappropriate and costly referrals. Making these services available in health departments and in school-based health centers contributes to beneficiary choice and enhances the coordination of physical and behavioral health services.

Goals of this service include:

a. preventing the development of serious emotional or behavioral problems in children and adolescents;
b. increasing effective coping and problem-solving skills of children, adolescents, and their parents;
c. facilitating effective communication between children and parents;
d. increasing parental understanding of child and adolescent development and behavior; and
e. strengthening the beneficiary's and family's support system to more effectively meet their needs.

## 1.1 Definitions

None Apply.

# 2.0 Eligibility Requirements

## 2.1 Provisions

### 2.1.1 General

**(*The term "General" found throughout this policy applies to all Medicaid policies*)**

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).

b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

### 2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

**a. Medicaid**

None Apply.

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the

beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

## 3.0 When the Procedure, Product, or Service Is Covered

***Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.***

### 3.1 General Criteria Covered

Medicaid shall cover procedures, products, and services related to this policy when they are medically necessary, and:

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

### 3.2 Specific Criteria Covered

#### 3.2.1 Specific criteria covered by Medicaid

All services must be medically necessary. A specific ICD-10-CM diagnosis code(s) must be present to substantiate medical necessity. Refer to **Attachment A, letter B**, for specific diagnostic codes that are covered under this policy. Services must meet **s**pecific requirements as specified in clinical coverage policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, at https://medicaid.ncdhhs.gov/

#### 3.2.2 Medicaid Additional Criteria Covered

None Apply.

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

***Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.***

## 4.1 General Criteria Not Covered

Medicaid shall not cover procedures, products, and services related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

## 4.2 Specific Criteria Not Covered

### 4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

### 4.2.2 Medicaid Additional Criteria Not Covered

These services are not covered for beneficiaries 21 years of age and older.

**Note for EPSDT:** For Medicaid beneficiaries under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

# 5.0 Requirements for and Limitations on Coverage

***Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.***

## 5.1 Prior Approval

Medicaid shall require prior approval for Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population. The provider shall obtain prior approval before rendering Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population.

## 5.2 Prior Approval Requirements

### 5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request;
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy; and

c. if the beneficiary is Medicaid eligible and is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

### 5.2.2 Specific

None Apply.

## 5.3 Additional Limitations or Requirements

Assessment services must always include the child or adolescent and in many cases should also include the parent or caregiver. Psychotherapy is focused on the needs of the child or adolescent but may include sessions with only the parents or caregivers when such sessions are in the interest of the child or adolescent. Individualized treatment plans must be designed to build upon strengths and overcome identified problems.

After a comprehensive psychosocial assessment using an age-appropriate tool or format, one of the following actions must occur:

a. The beneficiary's need for mental health intervention cannot be met by the health department or school-based health center mental health provider and an appropriate referral is made to another provider;
b. A treatment plan based on the beneficiary's strengths and needs and involving the beneficiary or family is developed and implemented for those beneficiaries to be followed through the public health system; or
c. If the assessment indicates no need for further psychosocial intervention services, this information is provided to the referral source as appropriate.

If a beneficiary is seen by a mental health provider in a health department or school-based health center and is referred and seen by a different provider for emergency mental health services on the same day, both providers may be reimbursed.

A beneficiary may receive psychological services in the health department or school-based health center sponsored by a health department in conjunction with mental health services provided by another agency, as long as services are coordinated and non-duplicative.

Outpatient behavioral health services must be provided in accordance with the requirements and procedures documented in clinical coverage policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers* at https://medicaid.ncdhhs.gov/, including the requirement to obtain a referral from the Community Care of North Carolina or Carolina Access (CCNC or CA) Carolina ACCESS primary care provider, the local management entity, or a Medicaid-enrolled psychiatrist for services provided to beneficiaries under the age of 21.

**Note:** Services provided by a physician do not require a referral.

# 6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### 6.1 Provider Qualifications and Occupational Licensing Entity Regulations

To provide Psychological Services, individuals shall be licensed in North Carolina and qualified as one of the following:
a. licensed clinical social worker (LCSW);
b. advanced practice psychiatric clinical nurse specialist (CNS);
c. advanced practice psychiatric nurse practitioner (NP); or
d. licensed psychologist.

All providers shall function within the scope of practice of their state license and certification.

Medical or other remedial care or services provided by licensed health care practitioners employed by Medicaid providers enrolled as health departments and school-based health clinics (sponsored by health departments) must be provided by or rendered under the overall direction and supervision of:

a. a physician licensed under state law to practice medicine or osteopathy, or
b. other individuals approved to perform medical acts, tasks, or functions (nurse practitioners, certified nurse midwives, physician assistants).

The supervising practitioner may be employed by or under contract with the health department or school-based health clinic. Supervision does not mean that the practitioner is required to be present when the service is rendered but shall be "immediately available" via telephone or pager.

### 6.2 Provider Certifications

None Apply.

## 7.0 Additional Requirements

***Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.***

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:
a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## 7.2 Additional Requirements

The following must be documented in the beneficiary's medical record:

a. reason for referral (or reason for visit);
b. assessment results from a standard assessment protocol;
c. diagnosis;
d. a treatment plan signed by clinician and beneficiary (parent or guardian for a younger child);
e. each intervention, including the date and duration of the session in minutes;
f. notes related to the treatment plan that describe the purpose of the contact, the nature of the intervention, and the effectiveness or outcome of the intervention (beneficiary's response to the intervention); and
g. signature and credentials of the person providing the service.

The following must also be documented, as appropriate:

a. consults with other professionals;
b. follow-up plan; and
c. release of information signed by beneficiary (parent or guardian for a younger child).

# 8.0 Policy Implementation and History

**Original Effective Date**

**Health Departments:** July 1, 2002

**School-Based Health Centers Sponsored by Health Departments:** November 1, 2000

| Date | Section Updated | Change |
|---|---|---|
| 12/01/2003 | Section 5.0 | The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage. |
| 12/01/2003 | Section 8.0 | Subsection numbers were added to the subsection titles. |
| 09/01/2005 | Section 2.0 | A special provision related to EPSDT was added. |
| 12/01/2005 | Subsection 2.3 | The Web address for DMA's EDPST policy instructions was added to this section. |
| 08/01/2006 | Section 5.0 | Information on referral requirements and a reference to Clinical Coverage Policy 8C was added to the end of the section. |
| 12/01/2006 | Subsection 2.3 | The special provision related to EPSDT was revised. |
| 12/01/2006 | Sections 3.0, 4.0, and 5.0 | A note regarding EPSDT was added to these sections. |
| 05/01/2007 | Sections 2 through 5 | EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age. |
| 07/01/2010 | All sections and attachment(s) | Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services. |
| 03/12/2012 | All sections and attachment(s) | Technical changes to merge Medicaid and NCHC current coverage into one policy. |
| 08/01/2014 | Subsection 5.3 | Inserted statement on referral that was included in previous versions but inadvertently left out of the current version. |
| 08/01/2014 | Attachment A | Revisions to update changes in the 2013 CPT code manual to include new codes and delete old codes. |
| 08/01/2014 | All Sections and Attachments | Replaced "recipient" with "beneficiary." |
| 08/01/2014 | All sections and Attachments | Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage. Replaced client with beneficiary. |
| 10/01/2015 | All Sections and Attachments | Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable. |
| 03/15/2019 | Table of Contents | Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP." |

| Date | Section Updated | Change |
|---|---|---|
| 12/15/2019 | Attachment A | Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis. |
| 12/15/2019 | Attachment A | Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis. |
| 12/15/19 | Table of Contents | Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP." |
| 12/15/19 | Attachment A | Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines. |
| 4/15/2023 | All Sections and Attachment(s) | Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023. |

# Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid.

## A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

## B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**Note:** Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

**Medicaid beneficiaries under the age of 21**

The provider may bill up to six (6) visits without a diagnosis of mental illness or a substance use disorder. The following provisions related to diagnosis codes may be used:

a. The first six (6) visits may be coded with an ICD-10 code corresponding to a DSM-5 "V" diagnosis code.
b. A specific diagnosis code shall be used as soon as a diagnosis is established.
c. Visits seven (7) and beyond require an ICD-10 code corresponding to a DSM-5 diagnosis code between 290 (Dementias) and 319 (unspecified intellectual disabilities).

**Note:** For a Medicaid beneficiary, these provisions related to diagnosis end on the last date of the birthday month in which a beneficiary turns 21 years of age.

Providers shall diagnose to the highest level of specificity using DSM-5, however, claims are submitted using ICD-10 diagnosis codes. Providers shall utilize the appropriate ICD-10 diagnosis that corresponds to the chosen DSM-5 diagnosis. A DSM-5 to ICD-10 crosswalk is found in the DSM-5 manual.

## C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of

service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.
If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Effective January 1, 2013, for health departments and school-based health centers sponsored by health departments, the following CPT codes may be billed for psychological services for the under-21 population:

| CPT Code(s) | Prior Authorization (PA) Unmanaged Visit Limits |
|---|---|
| 90785 | PA and visit limits do not apply; this code is an "add-on" to other codes (90791, 90792, 90832-90838, 90853) that do have PA and visit limits |
| 90791 | BH visit limits and PA requirements apply |
| 90832 | BH visit limits and PA requirements apply |
| 90834 | BH visit limits and PA requirements apply |
| 90837 | BH visit limits and PA requirements apply |
| 90839 | Two per calendar year, no PA required |
| 90840 | No PA required, Must be used with 90839; two add-ons per 90839 event |
| 90846 | BH visit limits and PA requirements apply; may not be used with 90785 |
| 90847 | BH visit limits and PA requirements apply; may not be used with 90785 |
| 90853 | BH visit limits and PA requirements apply |

**Unlisted Procedure or Service**
**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

## D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

## E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

## F. Place of Service

Place of service must be designated appropriately on the claim.

## G. Co-payments

For Medicaid refer to Medicaid State Plan:

https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

In accordance with 42 CFR 447.53 and 457.540, copayment may not be charged for Interactive Complexity (90785) service add-on.

## H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/