

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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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:
IH: Telehealth, Virtual Communications, and Remote Patient Monitoring

1.0 Description of the Procedure, Product, or Service

Health and Behavior Intervention provides intensive, focused counseling for pregnant and postpartum women who have serious psychosocial needs, which include individualized problem-solving, priority setting, instruction, and action planning to effect behavior modification or environmental change. It may include individualized treatment therapies designed specifically to aid in overcoming the identified problems. It may also include the involvement of the woman's significant other or other service providers.

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/>

2.3 Limitations

Pregnant and postpartum women who receive Medicaid and have one or more of the specified intensive psychosocial needs are eligible for this service.

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 the procedure, product, or service related to this policy when 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.

3.1.1 Telehealth Services

As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring*.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Health and Behavior Intervention is covered for pregnant or postpartum women with one or more of the following conditions:

- a. Substance use_(alcohol or drugs) or history of substance-use with potential negative impact on the current pregnancy;
- b. Child abuse, family violence, or severe family dysfunction or history of such problems with potential negative impact on the current pregnancy;
- c. Severe emotional crises associated with situations such as loss of job, divorce, homelessness, death, terminal illness;
- d. Episodic disorders: severe depression, psychosis, behavior disorders;
- e. Suicidal tendencies;
- f. Intense negative feelings about the current pregnancy;
- g. Intense negative feelings about previous poor pregnancy outcome such as fetal death, stillborn, infant death, or congenital abnormalities;
- h. HIV infection/AIDS and other life-threatening medical problems;
- i. Pending incarceration during the pregnancy; or
- j. Major psychological behavioral disorders such as anorexia.

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 the procedure, product, or service 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

None Apply.

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 not require prior approval for health and behavioral intervention.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

Health and Behavior Intervention services for pregnant and postpartum women should be face-to-face in the home or clinic (not the area mental health center). It can be provided by telephone when life-threatening situations exist.

Health and Behavior Intervention services may be provided in addition to services provided by the area mental health center. The two agencies may not provide the same service for the same reason or criteria. Counseling services must be coordinated to ensure continuity of care.

This short-term service may begin during the pregnancy and continue through the end of the month in which the 60th postdelivery day occurs. Long-term counseling needs may necessitate referrals to other providers.

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

To be eligible to bill for the procedure, product, or service 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

- a. Local health departments are eligible to provide this service.
- b. This service must be rendered by a licensed clinical social worker.

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 Documentation Requirements

Initial and subsequent client contacts must be documented. The Intensive Psychosocial Counseling Initial and Subsequent Assessment forms, a narrative note, or Subjective data, Objective data, Assessment, and Plan of Action (SOAP) note are acceptable forms for documentation. If the narrative note is used, the reason for the referral, presenting problem, summary/impression, treatment plan, and disposition must be included.

Screening tools may be used in conjunction with the assessment tool. The tools are used to help identify and screen specific psychosocial problems such as: alcohol and/or substance use, depression, HIV infection/AIDS, domestic violence or suicidal tendencies.

Confidentiality of the records must be maintained.

Coordination of care strategies must be identified by all caregivers to avoid duplication of services.

At a minimum, the client's record must include the following documentation:

- a. Beneficiary's name and date of birth.
- b. Beneficiary's Medicaid identification number (MID).
- c. Dates of service.
- d. Documentation of initial and subsequent contacts.
- e. Plan of treatment/care and outcome.
- f. Total service time component
- g. Name and title of person performing the service.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	Text stating that providers must comply with Medicaid guidelines was added to Section 8.0.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
3/1/11	Throughout	Updated policy with standard DMA template language and format
3/1/11	Attachment A	Updated billing guidelines to reflect transition from Maternity Care Coordination Program to Pregnancy Care Management Services
3/3/11	Attachment A	Revised to enhance integration with Pregnancy Medical Home/Pregnancy Care Management services
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/15	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."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/20/2019	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."
12/20/2019	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".
07/01/2020	3.2.2	Updated terminology substance abuse to substance use.
07/01/2020	7.2	Updated terminology substance abuse to

Date	Section Revised	Change
		substance use.
07/01/2020	7.2 (F)	Billing guidance removed as it no longer applies.
07/01/2020	Attachment A (C)	Remove end dated CPT codes 96152
07/01/2020	Attachment A (C)	Add CPT codes 96158 and 96159.
07/01/2020	Attachment A (E)	Billing unit removed as it no longer applies.
07/01/2020	Attachment A (H)	Billing guidance removed as it no longer applies.
07/01/2020	Attachment A (H)	Added new billing guidance
12/01/2020	Added Subsection 3.1.1	As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring.
12/01/2020	Attachment A, letter C	Added columns to health and behavior intervention codes indicating if the services were eligible for telehealth along with the following language: Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy
12/01/2020	Attachment A, letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring
12/01/2020	Attachment A, letter F	Added language indicating telehealth codes should be filed with the provider's usual place of service code(s)
12/01/2020	Added beginning of Policy	Added the language "This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect."
05/15/2022	Section 2.3	Removed postpartum definition
05/15/2022	Section 5.3	Replaced postpartum with postdelivery
05/15/2022		Policy has an amended date of 05/15/2022 with an effective date of 04/01/2022
8/15/2023	All Sections & Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 8/15/2023 with an

Date	Section Revised	Change
		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.

ICD-10-CM Code(s)		
O09.01	O09.42	O09.893
O09.02	O09.43	O09.91
O09.03	O09.511	O09.92
O09.11	O09.512	O09.93
O09.12	O09.513	Z33.1
O09.13	O09.521	Z34.01
O09.211	O09.522	Z34.02
O09.212	O09.523	Z34.03
O09.213	O09.611	Z34.81
O09.291	O09.612	Z34.82
O09.292	O09.613	Z34.83
O09.293	O09.621	Z39.0
O09.31	O09.622	Z39.2
O09.32	O09.623	
O09.33	O09.891	
O09.41	O09.892	

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.

CPT Code(s)	Telehealth Eligible Service
96158	Yes
96159	Yes

Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

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

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.

E. Billing Units

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

F. Place of Service

Beneficiary's home, office.

Telehealth claims should be filed with the provider's usual place of service code(s).

G. Co-payments

For Medicaid refer to Medicaid State Plan:

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

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for beneficiaries enrolled in the Medicaid managed care programs.

Health and Behavior Intervention is reimbursed for the first 30 minutes of service using CPT code 96158. Each additional 15 minutes is reimbursed using CPT code 96159. CPT code 96159 can only be billed after CPT 96158 has been billed first.

Total reimbursable time per day cannot exceed 60 total minutes of service. Eleven hours of Health and Behavior intervention services is allowed per pregnancy and postpartum. Claims for additional units will be considered for reimbursement through the adjustment process only when conditions of coverage are met, and documentation supports medical necessity.

Health and Behavior Intervention must be billed per date of service.

Note: Pregnancy Care Management providers must follow all applicable guidelines pertaining to per member per month reimbursement model (PMPM).