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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:

1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring

1A-38, Special Services: After Hours

8A, Enhanced Mental Health and Substance Abuse Services

8A-1, Assertive Community Treatment (ACT) Program

8J, Children's Developmental Services Agencies (CDSAs)

1.0 Description of the Procedure, Product, or Service

Outpatient behavioral health services are psychiatric and comprehensive clinical assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible beneficiaries.

Outpatient services for substance use disorders (SUD) are for beneficiaries assessed as meeting, at minimum, the American Society of Addiction Medicine (ASAM) level of 0.5 (Early Intervention) or 1.0 (Outpatient Services). Services include psychiatric and comprehensive clinical assessments, medication management, individual, group and family therapies, psychotherapy for crisis, psychological testing, and Screening, Brief Intervention, Referral, and Treatment (SBIRT).

These services determine a beneficiary's treatment needs and provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms to improve functioning in familial, social, educational, or occupational life domains. Outpatient behavioral health services often involve the participation of family members, natural support, and legally responsible person(s) as applicable, unless contraindicated.

The beneficiary's needs and preferences are based on collaboration between the practitioner and beneficiary to determine treatment goals, frequency and duration of services and measurable and desirable outcomes.

1.1 Definitions

a. Psychological Testing

Psychological testing involves the culturally and linguistically appropriate administration of standardized tests to assess a beneficiary's psychological or cognitive functioning. Testing results must inform treatment selection and treatment planning.

b. Psychotherapy for Crisis

On rare occasions, licensed outpatient service providers are presented with a beneficiary in crisis which may require unplanned extended services to manage the crisis in the office with the goal of averting more restrictive levels of care. Licensed professionals may use the "Psychotherapy for Crisis" CPT codes only in those situations in which an unforeseen crisis arises and additional time is required to manage the crisis event.

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A crisis is defined as an acute disturbance of thought, mood, behavior or social relationships that requires an immediate intervention, and which, if untreated, may lead to harm to the beneficiary or to others or have the potential to rapidly result in a catastrophic outcome. The goal of Psychotherapy for Crisis is stabilization, mobilization of resources, and minimization of further psychological trauma. Psychotherapy for Crisis services is a short-term emergency behavioral health intervention restricted to outpatient crisis assessment, stabilization, and disposition for acute, life-threatening situations.

c. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

SBIRT is an ASAM level 0.5 early intervention approach for a beneficiary with non-dependent substance use to effectively help them before more extensive or specialized treatment is needed. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for beneficiaries with substance use disorders, as well as those who are at risk of developing these disorders. The provider shall use a standardized screening tool, such as the Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST-10), or Screening to Brief Intervention (S2BI) tool.

Universal screening helps identify the appropriate level of services needed based on the risk level and determine if the beneficiary would benefit from brief intervention or referral to treatment services.

SBIRT services can be provided in a variety of settings by professionals included in **Section 6.0**, to systematically screen and assist beneficiaries who may not seek assistance for substance use problems. SBIRT services can:

1. reduce health care costs;
2. decrease the severity of drug and alcohol use;
3. reduce the risk of physical trauma; and
4. reduce the percentage of beneficiaries who go without specialized treatment.

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

- a. Medicaid
None Apply.

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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*

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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.

3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy can be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in clinical coverage Policy 1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring*, at <https://medicaid.ncdhhs.gov/>.

3.1.2 Telephonic Services

As outlined in **Attachment A**, select services within this clinical coverage policy can be provided via the telephonic, audio-only communication method.

Telephonic services must be transmitted between a beneficiary and provider in a manner that is consistent with the CPT code definition for those services.

This service delivery method is reserved for circumstances when:

- a. physical or behavioral health status prevent the beneficiary from participating in-person or telehealth services; or
- b. access issues (transportation, telehealth technology) prevent the beneficiary from participating in-person or telehealth services.

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Refer to **Subsection 3.2.2** for Telephonic-Specific Criteria; **Subsections 5.1 and 5.2** for Prior Approval requirements; and **Subsection 7.1** for Compliance requirements.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover outpatient behavioral health services when the beneficiary meets the following criteria:

3.2.1.1 Entrance Criteria

All of the following criteria are necessary for admission of a beneficiary to outpatient treatment services:

- a. A current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [(DSM-5) or any subsequent editions of this reference material] diagnosis;
- b. The beneficiary presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the current diagnosis;
- c. If a higher level of care is indicated but unavailable or the beneficiary is refusing the service, outpatient services can be provided until the appropriate level of care is available or to support the beneficiary to participate in that higher level of care;
- d. The beneficiary is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions;
- e. There is no evidence to support that alternative interventions would be more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Board of Addiction Medicine)

3.2.1.2 Continued Service Criteria

The criteria for continued service must meet both “a.” and “b.” below:

- a. Any ONE of the following criteria:
 1. The desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the beneficiary’s treatment plan;
 2. The beneficiary continues to be at risk for relapse based on current clinical assessment, and history: or
 3. Tenuous nature of the functional gains.
- b. Any ONE of the following criteria (in addition to “a.”)
 1. The beneficiary has achieved current treatment plan goals, and additional goals are indicated as evidenced by documented symptoms; or
 2. The beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that

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continuation of this service is expected to be effective in addressing the goals outlined in the treatment plan.

3.2.1.3 Discharge Criteria

Any ONE of the following criteria must be met:

- a. The beneficiary's level of functioning has improved with respect to the goals outlined in the treatment plan;
- b. The beneficiary or legally responsible person no longer wishes to receive these services; or
- c. The beneficiary, based on presentation and failure to show improvement, despite modifications in the treatment plan, requires a more appropriate best practice or evidence-based treatment modality based on North Carolina community practice standards (National Institute of Drug Abuse, American Psychiatric Association).

3.2.1.4 Psychological Testing Criteria

ALL of the following criteria are necessary entrance criteria for psychological testing services:

- a. A current DSM-5, or any subsequent editions of this reference material, diagnosis, or suspicion of such a diagnosis for which testing is being requested;
- b. The beneficiary presents with behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the current DSM-5, or any subsequent editions of this reference material, diagnosis;
- c. The beneficiary is capable of responding and engaging in psychological testing; and.
- d. There is no evidence to support that alternative tests would be more effective, based on North Carolina community practice standards (American Psychological Association).

3.2.1.5 Psychotherapy for Crisis Medical Necessity Criteria

Psychotherapy for Crisis is only covered when the beneficiary is experiencing an immediate, potentially life-threatening, complex crisis situation. The service must be provided in an outpatient therapy setting.

The beneficiary shall experience at least ONE of the following, supported by session documentation:

- a. Ideation, intent, and plan for harm to oneself or others; or
- b. Active psychosis possibly requiring immediate stabilization to ensure safety of self or others.

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3.2.2 Telephonic-Specific Criteria

Medicaid shall cover telephonic services when the following criteria are met:

- a. Providers shall obtain prior authorization in advance of delivering services via telephone only;
- b. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
- c. Providers shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
- d. The beneficiary's safety shall be carefully considered for the complexity of the services provided;
- e. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, their ability to assist and their safety is also considered;
- f. Delivery of services using telephonic, audio-only communication must conform to professional standards of care consisting of ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and Licensing Board rules;
- g. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented;
- h. Providers shall verify the beneficiary's identity using two points of identification before initiating a telephonic, audio-only encounter; and
- i. Providers shall ensure that beneficiary privacy and confidentiality is protected.

3.2.3 Medicaid Additional Criteria Covered

None Apply.

3.2.4 Best Practice or Evidence-Based Practice

Outpatient behavioral health service providers and those providing Psychotherapy for Crisis and psychological testing, shall be trained in and follow a rehabilitative best practice or evidence-based treatment model consistent with NC community practice standards. The treatment model must be expected to produce positive outcomes for the population being treated. The treatment model must address the clinical needs of the beneficiary identified in the comprehensive clinical assessment and on any subsequent assessments. Qualified interpreters shall be used, if necessary, to deliver test instructions in the examinee's preferred language.

Refer to **Section 5.0** for additional requirements and limitations.

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.

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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

4.2.1.1 Outpatient Behavioral Health

Medicaid shall not cover Outpatient Behavioral Health Services for the following:

- a. sleep therapy for psychiatric disorders;
- b. when services are not provided in-person or in accordance with Attachment A;
- c. when a beneficiary presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services;
- d. when the focus of treatment does not address the symptoms of the diagnosis;
- e. when the requirements and limitations in **Section 5.0** are not followed; and
- f. when Psychotherapy for Crisis codes are billed, the same provider shall not bill Special Services: After Hours codes. Refer to clinical coverage policy 1A-38, *Special Services: After Hours*, located on NC Medicaid's website at <https://medicaid.ncdhhs.gov/>, for the same event.

4.2.1.2 Psychological Testing

Medicaid shall not cover Psychological Testing for the following:

- a. for the purpose of educational testing;
- b. if requested by the school or legal system, unless medical necessity exists for the psychological testing;
- c. if the proposed psychological testing measures have no standardized norms or documented validity;
- d. if the service is not provided in-person or according to **Attachment A**;
- e. if the focus of assessment is not the symptoms of the current diagnosis; and
- f. when the requirements and limitations in **Section 5.0** are not followed.

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4.2.1.3 Psychotherapy for Crisis

Medicaid shall not cover Psychotherapy for Crisis under the following circumstances:

- a. if the focus of treatment does not address the symptoms of the current diagnosis or related symptoms;
- b. when services are not provided in-person or according to **Attachment A**;
- c. for routine psychotherapy not meeting medical necessity criteria outlined in **Subsection 3.2.1**;
- d. in emergency departments, inpatient settings, or facility-based crisis settings. Refer to **Attachment A(F)** for place of service;
- e. if the beneficiary presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services; and
- f. when the requirements and limitations in **Section 5.0** are not followed.

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 Outpatient Behavioral Health services. Refer to **Subsections 5.3.1.1 through 5.3.1.6** for limitations.

~~Prior authorization is not a guarantee of claim payment.~~

~~Note: Providers can seek prior approval if they are unsure the beneficiary has reached their unmanaged visit limit.~~

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

~~The provider(s) shall submit to the PHP, PIHP, or utilization management vendor (UM vendor) the following:~~

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

5.2.2 Specific

None Apply.

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Medicaid shall require prior approval for services provided via the telephonic, audio-only communication method.

5.3 Utilization Management and Additional Limitations

5.3.1 Utilization Management

None Apply.

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the Cherokee Indian Hospital Authority (CIHA), PIHP, PHP, or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly effective as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an authorization after the unmanaged units have been used, the Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA), service order for medical necessity, the treatment plan or Person-Centered Plan (PCP), and the required NC Medicaid authorization request form must be submitted to CIHA, the PIHP, PHP, or utilization management contractor prior to the unmanaged units ending. Refer to **Subsection 7.3.3.1**

5.3.1.1 Medicaid Beneficiaries under the Age of 21

Outpatient Behavioral Health Services have 16 unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes).

To ensure timely authorization, requests must be submitted prior to the 17th visit.

5.3.1.2 Medicaid Beneficiaries Ages 21 and Over

Outpatient Behavioral Health Services have a minimum of eight unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes).

To ensure timely prior authorization, requests must be submitted prior to the ninth visit.

For Medical Evaluation and Management (E/M) services, a beneficiary 21 years of age and over is allowed 22 unmanaged visits (exclusions apply, refer to <https://medicaid.ncdhhs.gov/>) counted separately from outpatient behavioral health services visit limits.

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5.3.1.13 Medicare - Qualified Beneficiaries (MQB)

Medicaid prior authorization is not required for MQB. Providers shall follow Medicare policies. For additional information on coordination of Medicare and Medicaid benefits, refer to **Attachment A**.

5.3.1.4 ~~Authorization for multiple providers for the same service~~

~~If clinically appropriate, providers may submit the same authorization request for up to three Medicaid Provider Numbers (MPNs) in one billing practice. All attending MPNs listed may be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary.~~

5.3.1.5 ~~Psychological testing prior approval requirements~~

~~Refer to **Subsection 7.5** for psychological testing prior approval requirements.~~

5.3.2 Additional Limitations

- a. Medicaid shall not allow the same services provided by the same or different attending provider on the same day for the same beneficiary.
- b. A written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment).
- c. Services provided by the licensed professionals listed in **Subsection 6.1** below, other than the Associate Level Professionals, do not require a separate written service order. These licensed professionals shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. The service order shall be signed prior to or on the first day of treatment (excluding the initial assessment.)
- d. If an urgent or emergent situation presents the need for a verbal service order, basic procedures must be followed for the verbal service order to be valid. Treatment may proceed based on a verbal service order by the appropriate professional as long as the verbal service order is documented in a beneficiary's service record on the date that the verbal service order is given. The documentation must specify the date of the verbal service order, who gave the order, who received the order, and identify each distinct service that was ordered. The documentation should reflect why a verbal service order was obtained in lieu of a written service order. The appropriate professional must countersign the service order with a dated signature within seventy-two (72) hours of the date of the verbal service order.
- e. Only one psychiatric CPT code from this policy is allowed per beneficiary per day of service from the same attending provider.
- f. Only two psychiatric CPT codes from this policy are allowed per beneficiary per date of service. These codes must be provided by two different attending providers.

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- g. Family therapy must be billed once per date of service for the identified family member only. No separate billing for participating member(s) of the therapy session, other than the identified family member, is permissible.
- h. If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that beneficiary.
- i. A Psychiatric Diagnostic Interview is not allowed on the same day as Psychological Testing when provided by the same provider. (See **Subsection 7.5** for additional information on Psychological Testing)
- j. There is a limit of eight hours of Psychological Testing allowed to be billed per date of service.
- ~~k. For substance use disorders, ASAM level 1 outpatient services are provided for less than nine hours a week for adults and less than six (6) hours a week for adolescents.~~
- l. Outpatient Medication Management and Outpatient Psychiatric Services cannot be billed while a beneficiary is **receiving** ~~authorized to receive~~ Assertive Community Treatment.
- m. Individual, Group, or Family Outpatient services cannot be billed while a beneficiary is **receiving:** ~~authorized to receive:~~
 - 1. Assertive Community Treatment (ACT);
 - 2. Intensive In-Home (IIH);
 - 3. Multisystemic Therapy (MST);
 - 4. Day Treatment;
 - 5. Substance Abuse Intensive Outpatient (SAIOP); or
 - 6. Substance Abuse Comprehensive Outpatient Treatment (SACOT).

5.4 Referral

All Outpatient Behavioral Health services provided to a Medicaid beneficiary can be self-referred or referred by some other source. If the beneficiary is not self-referred, the referral must be documented in the health record.

6.0 Providers 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, or be credentialed and contracted by the Cherokee Indian Hospital Authority; 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

In addition to physicians, the following providers can bill for these services:

- a. Licensed Psychologist (LP);
- b. Licensed Psychological Associate (LPA);

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- c. ~~Licensed Professional Counselor (LPC)~~ or Licensed Clinical Mental Health Counselor (LCMHC);
- d. ~~Licensed Professional Counselor Associate (LPCA)~~ or Licensed Clinical Mental Health Counselor Associate (LCMHCA);
- e. Licensed Clinical Social Worker (LCSW);
- f. Licensed Clinical Social Worker Associate (LCSWA);
- g. Licensed Marriage and Family Therapist (LMFT);
- h. Licensed Marriage and Family Therapist Associate (LMFTA);
- i. Licensed Clinical Addiction Specialist (LCAS);
- j. Licensed Clinical Addiction Specialist Associate (LCASA);
- k. Licensed Physician Assistant (PA);
- l. Nurse Practitioner (NP), including Psychiatric Mental Health Nurse Practitioner (PMHNP);
- m. Licensed Physician Assistants and Nurse Practitioners can be eligible to provide substance use disorder treatment prescriber services in an Opioid Treatment Program setting to Medicaid beneficiaries diagnosed with a substance use disorder if they meet the Federal opioid treatment standards under 42 CFR 8.12 and have an approved exemption from the Substance Abuse Mental Health Services Administration (SAMHSA.) These PAs and NPs must be supervised by a psychiatrist or other physician with experience practicing addiction medicine;
- n. Certified Clinical Nurse Specialist (CNS) certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an adult or child/adolescent Psychiatric Mental Health Clinical Nurse Specialist – Board-Certified.
- o. The licensed professional shall be direct-enrolled with Medicaid and have their own Medicaid Provider Number (MPN) and National Provider Identifier (NPI). Only the individual licensed professional assigned to those numbers can use those numbers for authorization and billing of services. These licensed providers cannot bill “incident to” a physician or any other licensed professional.

Professionals shall only provide treatment within the scope of practice, training, and expertise according to statutes, rules, and ethical standards of his or her professional occupational licensing board, and, as relevant, according to the scope outlined in a clinical supervision agreement.

All PAs and NPs providing psychiatric services must practice under the supervision of a psychiatrist.

Note: Per 25 USC 1621t “Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).”

Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health

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~~Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.~~

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, its divisions or its fiscal contractor(s). Federally recognized tribal and Indian Health Service (IHS) providers may be exempt to one or more of these items in accordance with Federal, Tribal laws and rules.

NC Medicaid Program Integrity or DHHS designated contractor may recoup payment if any service provided was not rehabilitative in nature such as habilitative or recreational activities or transportation. Rehabilitative means the same as defined in 42 C.F.R. 440.130(d).

7.2 Service Records and Documentation

7.2.1 Consent

At the time of the initial service, the provider shall obtain the written consent from the legally responsible person for treatment for beneficiaries of all ages.

7.2.2 Coordination of Care

The provider shall communicate and coordinate care with other professionals providing care to the beneficiary. The provider shall document coordination of care activities. Coordination of care activities can include:

- a. Written progress or summary reports;
- b. Telephone calls;
- c. Treatment planning processes. An individualized plan of care, service plan, treatment plan, or Person-Centered Plan (PCP), consistent with and supportive of the service provided and within professional standards of practice, is required according to **Subsection 7.3.4** below. When the beneficiary is receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the beneficiary, and outpatient behavioral health services are to be incorporated into the beneficiary's PCP;
- d. Coordination of care with the beneficiary's delegated care manager at the Advanced Medical Home (AMH), Clinically Integrated Network (CIN), Care Management Agency (CMA), the PHP or PIHP care manager, the

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Community Care of North Carolina (CCNC)/Carolina Access (CA) care manager, Tribal Option Care Manager, primary care, CCNC/CA physician or other NC DHHS recognized integrated care providers; and

- e. Coordination of care with PIHP or PHP.

Note: For coordination of care pertaining to billing, refer to **Attachment A**.

7.3 Clinical Documentation

7.3.1 Provision of Services

Providers shall maintain health records that document the provision of services for which Medicaid reimburses providers. Provider-organizations shall maintain, in each beneficiary's service record, at a minimum, the following documentation:

- a. Demographic information: the beneficiary's full name, contact information, date of birth, race, gender, and admission date;
- b. The beneficiary's name must be on each page generated by the provider agency;
- c. The service record number of the beneficiary must be on each page generated by the provider agency;
- d. The Beneficiary's Identification Number for services reimbursed by Medicaid must be on all treatment plans, service note pages, accounting of release, disclosure logs, billing records, and other documents or forms that have a place for it;
- e. An individualized treatment plan;
- f. Documentation of entrance criteria, continued service criteria, and discharge criteria;
- g. A copy of any testing, summary and evaluation reports;
- h. Documentation of communication regarding coordination of care activities; and
- i. All evaluations notes and reports must contain the full date the service was provided (month, day, and year).

7.3.2 Outpatient Crisis Services

Licensed professionals utilizing Psychotherapy for Crisis codes shall follow the following guidelines:

- a. Disposition may involve an immediate transfer to more restrictive emergency services (behavioral health urgent care center, facility-based crisis, emergency department, inpatient hospitalization) if documentation supports this decision.
- b. If the disposition is not an immediate transfer to acute or more intensive emergency services, the provider shall offer a written copy of an individualized crisis plan to the beneficiary. This plan must be developed in the session for the purpose of handling future crisis situations, including involvement of family and other providers as applicable. The plan must document a scheduled outpatient follow-up session.

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7.3.3 Comprehensive Clinical Assessment (CCA)

A CCA is an intensive clinical and functional evaluation of a beneficiary's presenting mental health, developmental disability, and substance use disorder. This assessment results in the issuance of a written report that provides the clinical basis for the development of the beneficiary's treatment or service plan. The CCA written report must be kept in the service record.

- a. A licensed clinician shall complete a CCA that contains an ASAM level of care determination on an eligible beneficiary diagnosed with a substance use disorder; and shall have documentation verifying the completion of training on the current 2013 ASAM Criteria edition, or any subsequent editions of this reference material, consisting at minimum of the following learning objectives:
 1. Review paradigm shifts and evolutions in generations of care that led to The ASAM Criteria;
 2. Apply The ASAM Criteria's decisional flow;
 3. Identify and describe the six ASAM criteria assessment dimensions;
 4. Rate risk and severity across all dimensions;
 5. Identify services and modalities needed, as well as treatment planning approaches;
 6. Identify appropriate levels of care;
 7. Review special populations and emerging research about addiction; and
 8. Develop strategies to overcome real-world barriers to implementing The ASAM Criteria.

Training must be a minimum of ten (10) hours to ensure the above identified learning objectives are addressed. It is expected that clinicians using the ASAM for CCAs completed for beneficiaries with a SUD seek out continuing education opportunities to maintain current knowledge of the ASAM criteria. Federally recognized tribal and IHS providers may complete an alternate curriculum to satisfy the identified learning objectives.

7.3.3.1 When a CCA is required

According to 10A NCAC 27G .0205(a), a comprehensive clinical assessment that demonstrates medical necessity must be completed by a licensed professional prior to provision of outpatient therapy services, including individual, family and group therapy. The clinician may complete the CCA upon admission or update a recent CCA from another clinician if a substantially equivalent assessment is available and reflects the current level of functioning. Information from that assessment may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and be included in the treatment or service plan.

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7.3.3.2 CCA Format

The format of a CCA is determined by the individual provider, based on the clinical presentation. Although a CCA does not have a designated format, the assessment (or collective assessments) used must contain **all** of the following elements:

- a. description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
- b. chronological general health, past trauma history and behavioral health history (consisting of mental health and substance use, and tobacco use) of the beneficiary's symptoms, treatment, and treatment response;
- c. current medications for medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions;
- d. a review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;
- e. evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
- f. analysis and interpretation of the assessment information with an appropriate case formulation, consisting of a determination of ASAM level of care when a substance use disorder is present;
- g. diagnoses using current the DSM-5, or any subsequent editions of this reference material, consisting of mental health, substance use disorders, or intellectual and developmental disabilities, as well as physical health conditions and functional impairment;
- h. recommendations for additional assessments, services, support, or treatment based on the results of the CCA; and
- i. The CCA must be signed and dated by the licensed professional completing the assessment.

7.3.3.3 A CCA is not required in the following situations:

- a. In primary or specialty medical care settings with integrated medical and behavioral health services, an abbreviated assessment is acceptable for the first six outpatient therapy sessions. If additional therapy sessions are needed, then a CCA must be completed.
- b. Due to the nature of crisis services, a CCA is not required prior to Psychotherapy for Crisis services. However, the provider shall comply with the 10A NCAC 27G .0205(a) requirement for an assessment prior to the delivery of any subsequent services.
- c. For medical providers billing E/M codes for medication management.

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7.3.3.4 Documentation in the health record must include the following:

- a. the beneficiary's presenting problem;
- b. the beneficiary's needs and strengths;
- c. a provisional or admitting diagnosis, with an established diagnosis within 30 calendar days;
- d. a pertinent social, family, and medical history; and
- e. other evaluations or assessments as appropriate.

7.3.4 Individualized Plan

An individualized plan of care, service plan, treatment plan, or PCP, referred to as "plan," consistent with and supportive of the service provided and within professional standards of practice, is required within 15 business days of the first face-to-face beneficiary contact. This plan is based on the assessment and is developed in partnership with the beneficiary or legally responsible person, or both. When services are provided prior to the establishment and implementation of the plan, strategies to address the beneficiary's presenting problem must be documented. The plan must be an identifiable document in the service record.

The plan must contain at a minimum:

- a. beneficiary outcomes that are anticipated to be achieved by provision of the service and a projected date of achievement;
- b. strategies;
- c. staff responsible;
- d. a schedule for review of the plan (in consultation with the beneficiary or legally responsible person or both) as needed but at least annually to review goals and strategies to promote effective treatment;
- e. basis for evaluation or assessment of outcome achievement; and
- f. written consent or agreement by the beneficiary or legally responsible person, or a written statement by the provider stating why such consent could not be obtained.

For a child or adolescent receiving outpatient substance use services, the plan must document both the staff and the child or adolescent's signatures demonstrating the involvement of all responsible parties in the development of the plan and the child or adolescent's consent or agreement to the plan. Consistent with N.C.G.S. § 90-21.5 or comparable federal, Tribal law, or rule, the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan must require the signature of the parent or legally responsible person for the child or adolescent demonstrating the involvement of the parent or legally responsible person in the development of the plan and the parent's or legally responsible person's consent to the plan.

The treatment plan must be updated as required, but a new plan is required at least annually.

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All treatment plans must be developed in partnership with the beneficiary or legally responsible person, and all updated or new plans require the beneficiary or legally responsible person's signature, and the licensed professional's signature. The licensed professional's signature on the updated or new plan can serve as the service order.

Note: Beneficiaries receiving medication management only would be exempt from the requirement of having to sign the treatment plan. For beneficiaries receiving medication management only and who have a legally responsible person, the legally responsible person would also be exempt from this requirement. Refer to **Attachment A, Section C** for E/M code documentation requirements. The treatment plan for beneficiaries receiving only medication management would not need to be a separate document and could be integrated into service notes.

7.3.5 Service Notes and Progress Notes

There must be a progress note for each treatment encounter that documents the following information:

- a. Date of service;
- b. Name of the service provided;
- c. Type of contact (in-person, telehealth, telephonic, or collateral); Services eligible to be provided via telehealth must be provided according to clinical coverage Policy 1-H, Telehealth, *Virtual Patient Communications*, and *Remote Patient Monitoring*, at <https://medicaid.ncdhhs.gov/>;
- d. Purpose of the contact (tied to the specific goals in the plan);
- e. Description of the treatment or interventions performed. Treatment and interventions must include active engagement of the beneficiary and relate to the goals and strategies outlined on the beneficiary's plan;
- f. Effectiveness of the intervention(s) and the beneficiary's response or progress toward goal(s);
- g. The duration of the service, length of the assessment or treatment in minutes;
- h. Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; and
- i. Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the beneficiary's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.

Note: The exception to the above service note policy is the documentation required for medical providers offering medication management and billing E/M codes. In this case, the medical provider must document the chosen E/M code with all of the necessary elements as outlined in the current edition of the American Medical Association's Current Procedural Terminology (CPT) manual.

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7.3.6 Referral and Service Access Documentation

a. Medicaid Beneficiaries under the Age of 21

For Medicaid beneficiaries under the age of 21, the following documentation must be kept in the health record:

1. The provider's signed treatment plan which serves as the service order.
2. A copy of the written service order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level professional.
- ~~3. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from the PHP, PIHP, or UM contractor is required.~~
3. All outpatient behavioral health services provided to a Medicaid beneficiary may be self-referred or referred by some other source. If the beneficiary is not self-referred, the referral must be documented in the health record.
4. Results of a beneficiary's ASAM Criteria, Third Edition and recommendations for Level 0.5 (Early Intervention) or 1.0 (Outpatient Services).
5. Reassessment(s) and recommendations of a beneficiary's ASAM Criteria, and referral(s) if more than the recommended six (6) hours a week of outpatient services are needed.

b. Medicaid Beneficiaries Aged 21 and Over

For Medicaid beneficiaries age 21 and over, the following documentation must be kept in the health record:

1. The provider's signed treatment plan serves as the service order.
2. A copy of the written order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level-professional.
- ~~3. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from the PHP, PIHP, or UM contractor is required.~~
3. All outpatient behavioral health services provided to a Medicaid beneficiary may be self-referred or referred by some other source. If the beneficiary is not self-referred, the referral must be documented in the health record.
4. Results of a beneficiary's ASAM Criteria, Third Edition and recommendations for Level 0.5 (Early Intervention) or 1.0 (Outpatient Services).
5. Reassessment(s) and recommendations of a beneficiary's ASAM Criteria, and referral(s) if more than the recommended nine (9) hours a week of outpatient services are needed.

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7.3.7 Electronic Signatures

When an electronic signature is entered into the electronic record by agency staff [employees or authorized individuals under contract with the agency], the standards for Electronic Signatures found in the September 2011 Medicaid Bulletin must be followed.

7.4 24-Hour Coverage for Behavioral Health Crises

Enrolled providers shall provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services. Enrolled providers shall arrange for coverage in the event that they are not available to respond to a beneficiary in crisis. This coverage must incorporate the ability for the beneficiary to speak with the licensed clinician on call either in-person, via telehealth, or telephonically.

7.5 Psychological Testing

The following are additional requirements pertaining to Psychological Testing services:

- a. ~~Unmanaged coverage is limited to eight (8) hours of service per state fiscal year for Psychological Testing services. Prior approval is required for services that will exceed the unmanaged limit. Prior approval assures medical necessity and authorizes the number of hours necessary to complete the psychological testing.~~
- b. The appropriate allowed Psychological Testing CPT code(s) shall be used.
- c. Billing for performing the Psychological Testing must occur only on a date(s) when the beneficiary is seen in-person. However, allowed Psychological Testing activities may occur on other dates when the beneficiary is not seen in-person and be billed using the appropriate Psychological Testing CPT code(s).
- d. A service note must be written for each Psychological Testing service(s) contact that includes:
 1. Name of the individual receiving this service;
 2. Service record number of the individual;
 3. Medicaid Identification Number (for services reimbursed by Medicaid);
 4. Date(s) of service documenting month, day, and year;
 5. Name of the service provided and CPT codes(s);
 6. Purpose of the psychological testing;
 7. Name(s) of the individual tests administered;
 8. Total amount of time to be billed on this date of service for psychological testing; and
 9. Signature and date signed of the psychologist, LPA, or physician with degree and licensure.

Note: Only one service note is required to be written for a Psychological Testing code(s) and an add-on code(s) if services are provided on the same day and by the same provider.

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This information serves to document the psychological testing service. The timeline for service notes documenting psychological testing is the same as other service notes and must be written or dictated within 24 hours of the day that the service was provided. After 24 hours the note is considered a late entry. If the note is not written or dictated within seven days of the day that the service was provided, the service may not be billed. After 24 hours, the note must be indicated as a late entry and must have a dated signature.

In addition to a service note for each encounter with the beneficiary, a written report of the psychological testing must be completed and sent to the individual or organization making the referral in a time frame according to beneficiary needs and clinical best practice standards. At a minimum this report must contain the following:

- a. Reason for the referral;
- b. Psychological tests/procedures utilized;
- c. Review of records as appropriate;
- d. Results of the psychological tests;
- e. Interpretation of the psychological tests;
- f. Summary;
- g. Diagnosis or Diagnostic Impression;
- h. Recommendations; and
- i. Signature, date signed, degree, and license of the psychologist, LPA, or physician.

Often psychological testing reports contain the information found in a Comprehensive Clinical Assessment (CCA).

7.6 Expected Clinical Outcomes

The expected clinical outcomes must relate to the identified goals in the beneficiary's treatment plan. The outcomes must reflect changes in symptoms and behaviors that, when met, promote increased functioning such that beneficiary no longer meets medical necessity criteria for further treatment. Expected clinical outcomes for this service are the following:

- a. Reduced symptomatology or abstinence, or decreased use of substances;
- b. Vocational or educational gains;
- c. Decreased engagement with the justice system;
- d. Stability in housing; and
- e. Increased social supports.

If a review of the need for ongoing treatment determines that continued treatment is medically necessary, documentation of continued stay must provide the following:

- a. documentation of the need for ongoing treatment; and
- b. documentation of progress made; or documentation of efforts to address lack of progress.

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8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 2005

Revision Information:

Date	Section Revised	Change
05/01/2005	Section 6.0	The requirements for nurse practitioners were revised to include a sunset clause that allows a five-year period for nurse practitioners who are certified in another specialty with two years of documented mental health experience a to obtain psychiatric certification.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
11/01/2005	Subsection 7.3.1	The requirement to list the beneficiary’s name and Medicaid identification number on each page of the medical record was revised; providers are required to list the beneficiary’s name and date of birth on each page of the medical record.
12/01/2005	Subsection 2.2	The Web address for NC Medicaid’s EDPST policy instructions was added to this section.
01/01/2006	Subsection 8.3	CPT code 96100 was end-dated and replace with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
09/01/2006	Section 6.0 and Subsection 8.3	Changed “certified” to “licensed” and abbreviations from CCS and CCAS to LCS and LCAS.
12/01/2006	Subsection 2.2	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	Subsection 8.3	Services provided by licensed clinical addictions specialists and certified clinical supervisors were expanded to include psychiatric and psychotherapeutic procedure codes. CPT code 90809 was added to the certified nurse practitioner block.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
06/01/2007	Section 6.0, Subsection 8.3	Updated the title of Licensed Clinical Supervisor to Certified Clinical Supervisor; deleted CPT codes from list of codes a Certified Clinical Supervisor may bill.
06/01/2007	Sections 3 and 4	Added standard statements of coverage conditions.
06/01/2007	Subsection 5.3.3	Created separate category for MQB beneficiaries.
06/01/2007	Subsection 8.2	Added “substance abuse” to the first list item lettered “a.”
06/01/2007	Subsection 8.3, 2nd paragraph	Changed “mental health specific codes” to “behavioral health-specific codes.”
01/01/2011	Subsection 5.3.1.c	Number of visits changed from 26 to 16
01/01/2011	Subsection 7.3.2.b	26 changed to 16
01/01/2011	Subsection 7.3.2.c	27 changed to 17
01/01/2011	Section 8.0	Moved to Attachment A
01/01/2011	Section 9.0	Becomes Section 8.0
01/01/2011	Section 7.0	Added standard EPSDT statement

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Date	Section Revised	Change
01/01/2011	Sections 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, 7.0	Updated with standard policy language
01/01/2012	Section 1.0	Behavioral health counseling deleted from description. Psychiatric medication management added.
01/01/2012	Subsection 5.1	Added “or different attending” and “for the same beneficiary” to item a. Updated language to b. Added items c, d, e, f, and g. e. Added administrative, civil and criminal action and shall be reported to occupational license board. f. Removed the example referring to scope of practice and provided clarification: provide treatment within the scope of practice, training, and expertise.
01/01/2012	Subsection 5.2	Changed Carolina Access to Community Care of North Carolina/Carolina Access (CCNC/CA). Added, “documentation of referral should be in the medical record. Added, must include name and NPI of referral source.
01/01/2012	Subsection 5.3	Changed 16 th visit to 17 th visit. A new written order is required within 12 months of initial visit and at least annually thereafter. Added piece on submitted prior approval requests prior to the 9 th visit for adults. Added Section on Authorization for multiple providers for the same service. Updated Place of Service section. Added note that prior approval for Medicaid 1915 (b)(c) waivers may vary from this policy. Revised section on prior approval. Added to 5.3.1, unmanaged visits inclusive of assessment and psychological testing codes. Revised Section 5.3.2.
01/01/2012	Subsection 5.4	Added clinic, nursing facility and other community settings to place of service. Revised Subsection 5.4.
01/01/2012	Subsection 5.5	Added section on Comprehensive Clinical Assessment (CCA). Clarified who may provide a CCA, incorporation of previous assessments in CCA, and documentation in service record.
01/01/2012	Subsection 5.6	Added Medical Necessity Criteria including Entrance, Continued Stay, and Discharge Criteria.

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Date	Section Revised	Change
01/01/2012	Section 6.0	<p>Added statement that licensed professionals must be direct-enrolled with Medicaid and must bill under own Medicaid Provider Number. Added sunset clause for Certified Clinical Supervisors to become licensed within 5 years. Added provisionally licensed professionals to the list of providers eligible to bill for service. Added Section 6.1 – Criteria for Billing ‘Incident To’ a Physician.</p> <p>Added other community settings as place of service for incident to. Added documentation of clinical supervision in the associate level licensed professional’s personnel record. Deleted: When services are provided to a dually eligible Medicare and Medicaid beneficiary, the physician must provide direct supervision. Added 6.0(c) on enrollment when serving dually eligible beneficiaries.</p>
01/01/2012	Subsection 7.1	Moved recoupment statement from Section 5 to Subsection 7.1.2
01/01/2012	Subsection 7.2	To subsection 7.2.3 c) added “An individualized plan of care, service plan, treatment plan, or Person-Centered Plan consistent with and supportive of the service provided and within professional standards of practice, is required on or before the day the service is delivered. When the beneficiary is receiving multiple behavioral health services in addition to the services in this policy, a Person-Centered Plan (PCP) must be developed with the beneficiary, and outpatient behavioral health services are to be incorporated into the beneficiary’s Person-Centered Plan. Added coordination of care with LME/MCO and added coordination of care activities are not billable. Revised Subsection 7.2.1.
01/01/2012	Subsection 7.3	Documentation changed to ‘Clinical’ Documentation. 7.3.1 Provision of Services was updated. 7.3.2 Service Plan added. 7.3.3 Service Notes/Progress Notes added/updated. Changed 7.3.2 heading to Individualized Plan. Clarified language regarding Plan development and removed conflicting language allowing 30 days to develop a Plan. Clarified signature requirements.
01/01/2012	Subsection 7.4	Section on Expected Clinical Outcomes added. Expected outcomes section was 7.4 and was renumbered 7.6 and 7.4 was renamed, Carolina Access changed to Community Care of North Carolina/Carolina Access (CCNC/CA). “Documentation of this referral shall be in the medical record” added. Referral and Service Access Documentation. Added to documentation requirements, the name and NPI of referral source must be included.

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Date	Section Revised	Change
01/01/2012	Subsection 7.5	Section was Referral and Service Access and was moved to 7.4. Section 7.5 is now named 24 Hour Coverage. Added requirement for providers to arrange for coverage when not available for beneficiaries in crisis.
01/01/2012	Subsection 7.7	Section on Coordination of Benefits added. Added Section A on dually eligible beneficiaries and added Section c stating that Medicaid is payor of last resort.
01/01/2012	Attachment A	Deleted all H Codes; Under Certified Clinical Supervisor, listed same CPT codes as Licensed Clinical Addiction Specialist; Added Provisionally Licensed Professionals billing 'incident to' with codes; added SC modifier to CPT codes billing 'incident to'; added information on use of modifiers and codes to use when the physician and associate level licensed see the beneficiary on the same day.
12/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
12/01/2012	Section 1.0	Provided an expanded definition of these services
12/01/2012	Subsection 3.2	Added Medical Necessity Criteria Entrance, Continued Stay and Discharge Criteria which had previously not been included in the policy
12/01/2012	Subsection 3.3	Added language to address the use of best and evidence-based practices in the delivery of these services and to require documentation of practitioner training in the specific treatment modalities used to deliver the services
12/01/2012	Subsection 4.2	Added provisions specifying when services are not covered including if the service is not delivered face to face, defined as including tele psychiatry; if symptoms related to diagnosis are not addressed; when the person cannot benefit from services; and psychological testing if it is for the purpose of educational or court assessment when there is no medical necessity for the testing and if the testing is not normed or have documented validity.
12/01/2012	Subsection 5.1	Added language relating that the requirements for unmanaged visits may vary under the LME/Prepaid Inpatient Health Plans.
12/01/2012	Subsection 5.5	Clarified language requiring a Comprehensive Clinical Assessment prior to providing treatment services and provided for an exception to this requirement for practitioners providing up to six (6) services in a primary care or specialty care medical setting, where services are generally more brief interventions, or screening or referrals if indicated; revised required components for the assessment.

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Date	Section Revised	Change
12/01/2012	Subsection 6.1	Specified that providers of these services must be licensed in North Carolina and be direct enrolled in Medicaid and that these providers are prohibited from allowing any other individual or practitioner to use their Medicaid number as this would be treated as Medicaid fraud and would be reported to Medicaid Program Integrity and to the practitioners licensing board. Also specifies that Professionals shall only provide treatment within the scope of practice, training, and expertise according to statutes, rules, and ethical standards of his or her professional occupational licensing board.
12/01/2012	Subsection 7.3.2	Added a requirement for an individualized plan of care, service plan, treatment plan, or Person-Centered Plan, hereinafter referred to as “plan,” consistent with and supportive of the service provided and within professional standards of practice, is required by the end of the first session.
12/01/2012	All sections and attachment(s)	Changed reference to the Medicaid utilization contractor to the DHHS Utilization Review Contractor.
12/01/2012	Subsection 5.5	Added psychological testing an exception to the CCA prior to providing services.
08/01/2013	Section 1	Sections 1.1 (Psychological Testing) and 1.2 (Crisis) were added to define these services
08/01/2013	Subsection 5.5	Section 5.5 was moved to Section 7.3.3
08/01/2013	Section 3.0	Medical Necessity Criteria specific to Outpatient Psychotherapy (Entrance, Continued, and Discharge criteria) was inserted as section 3.2.1, with separate criteria included for Psychological Testing (3.2.2) and Psychotherapy for Crisis (3.2.3)
08/01/2013	Subsection 4.2	Section 4.2.1 was inserted to specify non-covered criteria for Outpatient therapy, 4.2.2 was added with Psychological Testing coverage requirements; 4.2.3 was added for Psychotherapy for Crisis requirements.
08/01/2013	Section 5.0	Prior Approval was addressed for Psychotherapy for Crisis separate from psychological testing and psychotherapy; E/M Prior Approval requirements were added
08/01/2013	Subsection 5.3	Limitations were added to address Psychotherapy for Crisis billing rules (per CPT manual) (e-h added)
08/01/2013	Subsection 5.4.1	Added referral guidance for Psychotherapy for Crisis
08/01/2013	Subsection 7.3	A section on documentation for Psychotherapy for Crisis was inserted into 7.3.2; Comprehensive Clinical Assessment was inserted as 7.3.3, and subsequent sections were renumbered;
08/01/2013	Subsection 7.2.2 and 7.3.4	Plan requirement was changed from same day to within 15 business days
08/01/2013	All sections and attachment(s)	Changed reference to the Medicaid utilization contractor to the DHHS Utilization Review Contractor.

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Date	Section Revised	Change
08/01/2013	Attachment A	Added allowance for Providers to bill an intake or a psychological assessment with only a “V” code diagnosis
08/01/2013	Attachment A	Section C: added language to require providers to follow CPT manual; also supported this with E/M use
08/01/2013	Attachment A	Billing tables were deleted and replaced with a single billing table containing all providers, codes, and PA requirements
08/01/2013	Attachment A	A sentence was added to G to clarify that providers should not bill a separate copay for add-on codes/services
08/01/2013	Subsection 5.3	Added the limit of five hours of psychological testing per date of service.
08/01/2013	Subsection 3.2.5	Added Section 3.2.5 on Outpatient Crisis Services
08/01/2013	Attachment A Section C	Replaced the table of billing codes to reflect the new 2013 CPT codes.
08/01/2013	Subsection 3.2.4	Removed references to professional organizations not applicable to psychological testing and added reference to the American Psychological Association.
08/01/2013	Subsection 4.3.2	Removed walk-in clinics from the list of exclusions for Psychotherapy for Crisis.
08/01/2013	Subsection 7.3.4	Exempted medical providers who are providing only medication management from the requirement of having the beneficiary or legally responsible person sign the treatment plan.
08/01/2013	Attachment A, Section C	Specifies the documentation required for providers of E/M codes.
08/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage
08/01/2014	All Sections and Attachments	Updated: DSM-IV to DSM-5 language, American Society for Addiction Medicine language pertaining to substance use disorder, 2013 CPT codes, language pertaining to intellectual/ developmental disabilities, as well as other technical, nonsubstantive, and clarifying language/grammar changes.
08/01/2014	Subsection 5.4.1	Added clarification that referrals are required prior to or on the first date of service.
08/01/2014	Subsection 6.2	Clarified that the Associate Level Provider can continue to bill Incident To the physician or the LME/MCO until DMA is able to directly enroll the Associate Level Professional.
10/1/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/1/2015	All Sections and Attachments	Reviewed policy language for technical and grammatical errors and amended as needed to improve clarity.
10/1/2015	Subsection 3.2.1.1	Clarified entrance criteria pertaining to providing outpatient services when the beneficiary is assessed to need a higher level of care.

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Date	Section Revised	Change
10/1/2015	Subsection 5.2.2	Allowed for fully licensed providers signature on their treatment plan to serve as an order for service as has been the case for psychologists and physicians. Also, clarified the requirements for documenting treatment plans.
10/1/2015	Subsection 5.4	Removed the requirement that children need a referral prior to services.
10/1/2015	Section 6.1	Extended the enrollment of nurse practitioners certified in another specialty to June 30, 2017 and gave notice that, in future, Physician Assistants will be required to directly enroll.
10/1/2015	Subsection 6.1	Included associate level providers as able to directly enroll.
10/1/2015	Subsection 6.2	This section was removed from the policy as Associate Level Professionals must be directly enrolled and the incident to billing has been discontinued.
10/1/2015	Subsection 7.2.2	Modified section on coordination of care to be less prescriptive.
10/1/2015	Subsection 7.3.3	Clarified that the CCA must be signed and dated by the licensed professional completing the assessment. Outlined the documentation requirements for the assessment that must be done if services are initiated prior to the full CCA being completed.
10/1/2015	Subsection 7.3.4	Clarified the requirements of the treatment plan bringing this section into compliance with administrative code. Also clarified that the plan shall be an identifiable document in the service record.
10/1/2015	Subsection 7.4	Clarified that 24-hour coverage for crises included the ability for the beneficiary to speak to a licensed clinician either face-to-face or telephonically.
10/1/2015	Subsection 7.5	Added this section outlining the requirements for psychological testing.
7/1/2017	Subsection 6.1	Revised section pertaining to Nurse Practitioners to allow Nurse Practitioners not yet certified as Psychiatric Mental Health Nurse Practitioners with supervised experience to enroll.
7/1/2017	Attachment A	Removed the specific date for the CPT manual and added the associate level providers to the CPT code table.
7/1/2017	Subsection 5.2.2	Clarified that Associate Level providers require a service order.
11/15/2018	Subsection 6.1 and Attachment A	Physician Assistants no longer able to bill “incident to” a physician and would have to be directly enrolled in order to provide behavioral health services under this policy.

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Date	Section Revised	Change
03/01/2019	Subsection 7.5	Removed prior approval is required for all hourly Psychological Testing code requests of over eight hours even if the beneficiary has available unmanaged benefits and replaced with language that specified limits for unmanaged coverage. Removed the exception to event-based psychological testing CPT codes. Removed the hours billed using the CPT code may include time spent performing the clinical interview, reasonable review of pertinent health records, performing the authorized Psychological Testing, scoring the Psychological Testing, interpreting the results of the Psychological Testing, and preparing a written report. Removed each CPT code equals one unit even though a psychological testing CPT code may involve multiple hours of testing; and thus, five hours of psychological testing using a single testing code would count as one unit towards the beneficiary’s managed or unmanaged visits. Specified requirements of writing service notes.
03/01/2019	Attachment A	Removed the provider shall bill one diagnostic assessment (90791 or 90792) and up to five (5) units of one psychological testing assessment (96101, 96116, 96118) without a diagnosis of mental illness or a substance use disorder. These visits may be coded with an ICD-10 code corresponding to a DSM-5 “V” diagnosis code. All other visits require an ICD-10 code corresponding to a DSM-5 diagnosis code between 290 and 319.
03/01/2019	Attachment A	Added CPT Coding changes for Psychological and Neuropsychological Testing Services were effective January 1, 2019. Medicaid: CPT procedure code 96101 was end-dated and replaced with 96130, 96136, and 96137; 96111 was end-dated and replaced with 96112 and 96113; 96121 was added to 96116; 96118 was end-dated and replaced with 96132, 96133, 96136 and 96137. The URL for a list of diagnoses exempt from the annual visit limitation corrected.
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.
12/15/2019	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.

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Date	Section Revised	Change
12/15/2019	Attachment A	Added: Note: North Carolina Medicaid and North Carolina Health Choice will not reimburse for conversion therapy.
12/15/19	Attachment A	Removed: Note: For behavioral health diagnosing, it is recommended that providers diagnose to the highest level of specificity using DC 0-5, however, claims are submitted using ICD-10 diagnosis codes. Providers shall utilize the appropriate ICD-10 diagnosis that corresponds to the chosen DC 0-5 diagnosis. A DC 0-5 to ICD-10 crosswalk is found in the DC 0-5 manual.
12/15/2019	Attachment A	Added Psychological and Neuropsychological Testing Services CPT Coding 96138, 96139, and 96146.
12/15/2019	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.”
01/01/2021	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.
01/01/2021	Related Clinical Coverage Policies	1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring
01/01/2021	Subsection 3.1.1	Added new subsection 3.1.1 Telehealth Services.
01/01/2021	Subsection 3.1.2	Added new subsection 3.1.2 Telephonic Services
01/01/2021	Subsection 3.2.2	Added new subsection 3.2.2 Telephonic-Specific Criteria
01/01/2021	Subsection 4.2.1.1	Deleted “face to face”; added “in-person or in accordance with Attachment A, Letter C (Codes)”. Updated language: Note: Services eligible to be provided via telehealth must be provided according to the guidelines of Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring located on NC Medicaid’s website at https://medicaid.ncdhhs.gov/ .

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Date	Section Revised	Change
01/01/2021	Subsection 4.2.1.2	Deleted: “face to face”; added: “in-person or in accordance with Attachment A, Letter C (Codes)”. Deleted: Note: Services provided according to the guidelines of clinical coverage policy 1H, Telemedicine and Telepsychiatry, located on NC Medicaid’s website at https://medicaid.ncdhhs.gov/ , are considered as face-to-face services.
01/01/2021	Subsection 4.2.1.3	Added: “b. when services are not provided in-person or in accordance with Attachment A;”
01/01/2021	Subsection 5.1	Added: “Excluding psychotherapy for crisis services, Medicaid and NCHC shall require prior approval for services provided via the telephonic, audio-only communication method. Refer to Subsections 5.2 and 5.3 for limitations.”
01/01/2021	Subsection 6.1	Added: “Licensed Clinical Mental Health Counselor (LCMH)” and “Licensed Clinical Mental Health Counselor Associate (LCMHA)” to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.
01/01/2021	Subsection 6.1	Added: “Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.”
01/01/2021	Subsection 7.3.3	Deleted: “face-to-face”.
01/01/2021	Subsection 7.3.5	Updated type of contact.
01/01/2021	Subsection 7.4	Deleted: “face-to-face”. Added: “in-person, telehealth”.
01/01/2021	Subsection 7.5	Deleted: “face-to-face” and replaced with “in-person”. Added “with the beneficiary”.

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Date	Section Revised	Change
01/01/2021	Attachment A, Letter C	Added columns to service codes indicating if the services were eligible via telehealth and telephonic. Added: “LCMH” and “LCMHA” to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized. Added: “Note: The “+” symbol identifies add-on codes that are performed in addition to the primary service or procedure code when medically necessary and must never be reported as stand-alone codes.” Added “Note: Telehealth and telephonic eligible services may be provided to both new and established beneficiaries by the eligible providers listed within this policy.” Added: “Note: Please refer to Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring for virtual patient communications and remote patient monitoring utilization and billing guidance.”
01/01/2021	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 monitoring
01/01/2021	Attachment A, Letter F	Telehealth claims should be filed with the provider’s usual place of service code(s)
09/01/2021	Section 6.0, Letter h	Acronym for Licensed Marriage and Family Therapist Associate, LMFTA, added.
09/01/2021	Section 6.0, Letter j	Spelling of acronym for Licensed Clinical Addiction Specialist Associate, LCASA, corrected.
09/01/2021	Attachment A, Letter C	Telehealth eligible column checked for add-on code 90836. Telephonic eligible column for add-on code 90838 unchecked.

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03/01/2023	Subsection 1.0	To ‘Related Clinical Coverage Policies’ added- 8A Enhanced Mental Health and Substance Abuse Services, 8A-1 Assertive Community Treatment (ACT) Program, and 8J-Children’s Developmental Services Agencies (CDSAs)’ Added statement: Outpatient services for Substance Use Disorders are identified and based on the American Society of Addiction Medicine (ASAM) criteria. Added c.- Screening, Brief Intervention, and Referral to Treatment (SBIRT) definition
03/01/2023	Subsection 3.1.1	Added subsection for telehealth services
03/01/2023	Subsection 3.1.2	Added subsection for telephonic services
03/01/2023	Subsection 3.2.1.1	Removed ‘Note’ from a., removed b., replaced ‘individual’ with ‘beneficiary’.
03/01/2023	Subsection 3.2.1.4	Added ‘current, or any subsequent editions of this reference material diagnosis’ to DMS-5 in a. and b.
03/01/2023	Subsection 4.2.1.1	Deleted Note referencing telehealth
03/01/2023	Subsection 4.2.1.2	Deleted d., deleted Note following d., added e. ‘if the service is not provided in-person or according to Attachment A;’
03/01/2023	Subsection 4.2.1.3	a. added ‘current’, added b.- ‘when services are not provided in-person or according to Attachment A’
03/01/2023	Subsection 5.1	Edited sentence to state ‘Medicaid and NCHC shall not require prior approval for Outpatient Behavioral Health Services’ referred to subsections 5.3.1.1, 5.3.1.2, 5.3.1.3, 5.3.1.4, 5.3.1.5, and 5.3.1.6. Deleted language regarding prior approval, moved language addressing unmanaged units to subsection 5.3- Utilization Management and Additional Limitations
03/01/2023	Subsection 5.2.1	Replaced DHHS UR Contractor with PIHP, PHP, or utilization management contractor

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03/01/2023	Subsection 5.2.2	Added ‘Medicaid and NCHC shall require prior approval for services provided via the telephonic, audio-only communication method’ Moved sections 5.2.2.1, 5.2.2.2, 5.2.2.3, 5.2.2.4, 5.2.2.5, and 5.2.2.6 to Section 5.3- Utilization Management and Additional Limitations
03/01/2023	Subsection 5.3	Renamed subsection to ‘Utilization Management and Additional Limitations’ Added section 5.3.1- Utilization Management Added Section 5.3.1.1, 5.3.1.2, 5.3.1.3, 5.3.1.4, 5.3.1.5, 5.3.1.6 Added Section 5.3.2- Additional Limitations, added b., c. and d addressing signature requirements for licensed staff and associate licensed staff and verbal service orders; edited e. to remove ‘This consists of medication management services’; deleted h. and i. addressing psychotherapy for crisis limitations; edited j. to indicate ‘eight hours of Psychological Testing allowed to be billed per date of service’; added k. addressing outpatient services for beneficiaries with SUD, added l. and m. to address service exclusions.
03/01/2023	Subsection 6.0	Added to b. ‘or be credentialed and contracted by the Cherokee Indian Hospital Authority’
03/01/2023	Subsection 6.1	Deleted statement regarding incident to billing, added l. ‘Nurse Practitioner (NP), including Psychiatric Mental Health Nurse Practitioner (PMHNP)’, deleted Note regarding LME/MCO contracting requirements, deleted m., n., edited o. to address Licensed Physician Assistances and Nurse Practitioners working in Opioid Treatment Programs and the requirements that must be met, deleted subsections i. through iv. and the two paragraphs following iv., deleted Note- after p., added that licensed providers cannot bill ‘incident to’, added statement that professionals must work within their scope of practice, training and expertise, deleted statements addressing program integrity, deleted Note addressing LME-MCO contracting requirements, added Note addressing Tribal exemptions, added Note addressing NC General Assembly Session Law 2019-240, Senate Bill 537
03/01/2023	Subsection 7.1	Added to b. ‘Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with Federal, Tribal laws and rules.’

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03/01/2023	Subsection 7.2.2	Added to d. ‘delegated care manager at the Advanced Medical Home (AMH), Clinically Integrated Network (CIN), Care Management Agency (CMA), the PHP or PIHP care manager, the CCNC/CA care manager, and Tribal Option Care Manager or other NC DHHS recognized integrated care providers;
03/01/2023	Subsection 7.3.2	Added to a. ‘behavioral health urgent care center, facility-based crisis, emergency department’
03/01/2023	Subsection 7.3.3	Added a. to address ASAM training requirements
03/01/2023	Subsection 7.3.3.2	Added to b.- past trauma history Added to c.- ‘medical, psychiatric, and substance use disorder,’ and ‘identify past medications that were ineffective or caused significant side effects or adverse reactions.’ Added to h.: including a determination of American Society of Addiction Medicine (ASAM) level of care when a substance use disorder is present. Added to i.- ‘using current DSM-5 or any subsequent editions of this reference material’
03/01/2023	Subsection 7.3.4	Deleted reference to 10A NCAC 27G .0205(d) Added: “or comparable federal, Tribal law, or rule”
03/01/2023	Subsection 7.3.6	Corrected criteria Replaced DHHS UR Contractor with PIHP, PHP, or utilization management contractor
03/01/2023	Subsection 7.6	Revised Expected Clinical Outcomes
03/01/2023	Attachment A.	Added to Claims Related Information- ‘Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:’ Added to Billing Units- ‘Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law. Added ‘SBIRT services must only be billed when a clinician provides screening and brief intervention. If a brief intervention is not clinically indicated, time spent providing the screening should be included in the time for other services rendered.’

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03/01/2023	Attachment A, Chart	Renamed ‘Psych NP/PA’ column to ‘PMHNP’, deleted column 4 ‘PA Incident to’ and replaced with ‘PA/NP’, in column 7- renamed to Code Guidance/Unmanaged Visit Limits and deleted ‘Prior Authorization’, in column 7 deleted references to ‘prior authorization requirements’ Added Telehealth to the following codes: 99408, 99409, 96110, 96130, 96131, 96132, 96133, 96143 Added to E. Billing Units- ‘Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal law’ Set PMHNP codes to include E/M codes, SBIRT, and psychotherapy Set PA/NP codes to include E/M codes, SBIRT, and 90792 only, no psychotherapy codes
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.
11/01/2023	Attachment A: Claims-Related Information	Updated CPT code 96121 to telehealth eligible.
11/01/2023		Policy posted 11/06/2023 with an amended date of 11/01/2023
	<u>All Sections & Attachments</u>	<u>To comply with the Mental Health Parity and Addiction Equity Act and the Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900 language referencing prior approval, authorizations, utilization management and unmanaged units and visits have been removed.</u>
	<u>Subsection 5.3.2 (k)</u>	<u>ASAM language removed from 5.3.2 (k).</u>
	<u>Section 6.1</u>	<u>Effective 01/01/2024, 10A NCAC 27G .0104 Staff Definitions (15) "Licensed Clinical Mental Health counselor (LCMHC)" replaced "Licensed Professional Counselor (LPC)". Removed "Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized."</u>
	<u>Subsection 7.3.6 (a)</u>	<u>Removed 7.3.6 (a)(3): For visits beyond unmanaged visits, a copy of the completed authorization request form and prior approval notification from the PHP, PIHP, or UM contractor is required. Added documentation requirements for The ASAM Criteria, Third Edition added.</u>

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	<u>Subsection 7.3.6(b)</u>	Removed 7.3.6 (b)(3): For visits beyond unmanaged visits, a copy of the completed authorization request form and prior approval notification from the PHP, PIHP, or UM contractor is required. Added documentation requirements for The ASAM Criteria, Third Edition added.
	<u>Subsection 7.5</u>	Removed a. Unmanaged coverage is limited to eight (8) hours of service per state fiscal year for Psychological Testing services. Prior approval is required for services that will exceed the unmanaged limit. Prior approval assures medical necessity and authorizes the number of hours necessary to complete the psychological testing.
	<u>Attachment A: Claims-Related Information</u>	Removed reference to LPC and LPCA. Removed CCS which is not a standalone licensure to bill for services. Unmanaged Visits Limits of table renamed “Add-On Code Limits”. Removed BH visit limits, E/M Visit limits and no PA required.

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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.

Note: Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

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 diagnosis code(s) 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.

Medicaid beneficiaries under the age of 21 and older

The provider can bill up to six 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 visits can be coded with an ICD-10 code corresponding to a DSM-5 “V” diagnosis code.
- b. A specific diagnosis code must be used as soon as a diagnosis is established.
- c. Visits seven 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.

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.

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), ICD-10 procedure codes, 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.

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It is each billing provider's responsibility to read, understand, and ensure compliance with published CPT guidance and NC Medicaid policy for services billed to Medicaid and PIHP s. There is no substitute for reading the CPT manual. There are limitations to use of code combinations and documentation requirements listed in the manual that are not listed in this policy, but which providers must adhere to when billing Medicaid.

Physicians bill appropriate CPT codes which can contain Evaluation and Management (E/M) codes. E/M codes are not specific to mental health and are not subject to prior approval. These codes are subject to the annual visit limit for adults. For Medicaid beneficiaries under the age of 21 there is no limit to E/M codes allowed per state fiscal year.

Physicians billing E/M codes with psychotherapy add-on codes must have documentation supporting that the E/M service was separate and distinct from the psychotherapy service.

Documentation of E/M codes must follow the guidelines in the current version of the American Medical Association's Current Procedural Terminology (CPT) codebook. Documentation must support the code billed and all of the components of the code selected must be documented.

Behavioral health-specific codes are billable by physicians according to the services they render and would be subject to prior approval if utilized. Other providers bill specific codes as indicated in the following CPT code table.

SBIRT services must only be billed when a clinician provides screening and brief intervention. If a brief intervention is not clinically indicated, time spent providing the screening must be incorporated in the time for other services rendered.

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Psychiatric Diagnostic Evaluation, Psychotherapy, Medication Management, Crisis, and Psychological Testing CPT Codes

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, and CNS	Unmanaged Visit Limit Add-On Code Limits	Telehealth Eligible	Telephonic Eligible
+90785	X	X	X	X	X	This code is an "add-on" to other codes (90791, 90792, 90832-90838, 90853) that do have PA and visit limits	X	X
90791	X	X		X	X	BH visit limits apply	X	
90792	X	X	X			BH visit limits apply	X	
90832	X	X		X	X	BH visit limits apply	X	X
+90833	X	X				BH visit limits apply; code Code must be used with E/M code	X	
90834	X	X		X	X	BH visit limits apply	X	X
+90836	X	X				BH visit limits; code Code must be used with E/M code	X	
90837	X	X		X	X	BH visit limits apply	X	X
+90838	X	X				BH visit limits; code Code must be used with E/M code	X	
90839	X	X		X	X	No PA required	X	X
+90840	X	X		X	X	Code must Must be used with 90839;	X	X

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Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, and CNS	Unmanaged Visit Limit Add-On Code Limits	Telehealth Eligible	Telephonic Eligible
90846	X	X		X	X	BH visit limits; may May not be used with 90785	X	X
90847	X	X		X	X	BH visit limits; may May not be used with 90785	X	X
90849	X	X		X	X	BH visit limits; may May not be used with 90785	X	X
90853	X	X		X	X	BH visit limits apply	X	X
E/M Codes: 99202-99255; 99304-99337; 99341-99350; 99417	X	X	X			E/M Visit limit is separate; NC Medicaid established adult limit is 22, does not count toward BH limits; Limit does not apply to diagnoses listed here: https://files.nc.gov/ncdema/ced-10-exempt-diagnoses-11062018.pdf or to beneficiaries under 21.	X Telehealth eligible codes are limited to the following: <ul style="list-style-type: none"> • 99202-99205 • 99211-99215 • 99231-99233 • 99238-99239 • 99241-99245 • 99251-99255 • 99347-99350 	
99408:	X	X	X	X	X	No PA required	X	
99409:	X	X	X	X	X	No PA required	X	

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Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC, LCMHCA, LPC, LPCA , LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS , and CNS	Unmanaged Visit Limit Add-On Code Limits	Telehealth Eligible	Telephonic Eligible
96110	X	X		X		BH visit limits apply	X	
96112	X			X		BH visit limits apply		
96113	X			X		BH visit limits apply; Must be used with 96112		
96116	X			X		No PA required	X	
96121	X			X		BH visit limits apply; Must be used with 96116	X	
96130	X			X		BH visit limits apply	X	
96131	X			X		BH visit limits apply; Must be used with 96130	X	
96132	X			X		No PA required	X	
96133	X			X		Must be used with 96132	X	
96136	X			X		Must be used with 96130 or 96132		
96137	X			X		Must be used with 96136		
96138	X			X		No PA required		
96139	X			X		Must be used with 96138		
96146	X			X		No PA required	X	

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Note: The “+” symbol identifies add-on codes that are performed in addition to the primary service or procedure code when medically necessary and must never be reported as stand-alone codes.

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.

Note: Please refer to Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring for utilization and billing guidance on virtual patient communication codes (e.g., online digital E&M, telephonic E&M, and interprofessional consultation) and remote patient monitoring codes (e.g., self-measured blood pressure and remote physiologic monitoring) billable by eligible psychiatric prescribers but which are not contained in Clinical Coverage Policy 8C.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines. Documentation in the record must clearly indicate who provided the service.

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 services provided via telephonic, audio-only communication.

Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

E. Billing Units

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s). 1 CPT code = 1 unit of service.

Note: Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service

a. Medicaid Beneficiaries under the Age of 21

Office, clinics, schools, homeless shelters, supervised living facilities, alternative family living facilities (AFL), assisted living nursing facilities, home, and other community settings as clinically indicated.

b. Beneficiaries Aged 21 and Over

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Office, clinics, homeless shelters, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, adult care homes, nursing facilities, home, and other community settings as clinically indicated.

Telehealth and telephonic 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-notice/medicaid-state-plan-public-notice>

In accordance with 42 CFR 447.53 and 457.540, a co-payment may not be charged for Interactive Complexity (90785) service add-on or for psychotherapy add-on codes separately. One co-payment is allowed per office visit.

H. Reimbursement

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

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

Note: North Carolina Medicaid will not reimburse for conversion therapy.

I. Coordination of Care

- a. Coordination of care activities are included in the administrative costs for this service and are therefore not billable.
- b. Coordination of Benefits for Medicaid Beneficiaries
 1. Any provider who serves dually eligible beneficiaries (i.e., Medicaid and Medicare or other insurance carriers) shall be enrolled as a participating provider with each of the identified insurance carriers in order to be reimbursed.
 2. For beneficiaries having both Medicaid and Medicare, the provider shall bill Medicare as primary before submitting a claim to Medicaid. If both Medicare and Medicaid allow the service, Medicaid pays the lesser of:
 - A. the Medicare cost-sharing amount; or
 - B. the Medicaid maximum allowable for the service less the Medicare payment.
 3. For beneficiaries having both Medicaid and any other insurance coverage, the other insurance shall be billed prior to billing Medicaid, as Medicaid is considered the payor of last resort.