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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:
8-A, Enhanced Mental Health and Substance Abuse Services
8-A-1, Assertive Community Treatment (ACT) Program
1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

1.0 Description of the Procedure, Product, or Service

Peer Support Services (PSS) ~~are~~ is an evidenced-based ~~mental health~~ model of care that provides community-based recovery services directly to a Medicaid-eligible adult beneficiary ~~diagnosed~~ with a Serious Mental Illness (SMI) ~~mental health~~ or substance use disorder (SUD) diagnosis. PSS provides structured, scheduled ~~services~~ interventions that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills ~~of~~ for a eligible beneficiary.

PSS ~~services are~~ is directly provided by North Carolina Certified Peer Support Specialists (CPSS) self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS is intended to complement clinical and other medically necessary services and is typically delivered in coordination with services that address a beneficiary's mental health or SUD diagnosed condition. ~~PSS can be provided in combination with other approved mental health or substance use services or as an independent service.~~

~~Due to the high prevalence of beneficiaries with co-occurring disorders (mental health, substance use or physical health disorders) it is a priority that integrated treatment be available to these beneficiaries.~~

PSS ~~are~~ is based on the belief that a beneficiary diagnosed with a serious mental illness ~~health~~ or substance use disorder~~s~~ diagnosis can and do recover. The focus of the service~~s~~ is on ~~the~~ ~~person~~ a beneficiary's strengths, rather than the identified serious mental illness ~~health~~ or substance use disorder and emphasizes the acquisition, development, and expansion of rehabilitative skills needed to ~~move forward in~~ establish and maintain recovery. The service~~s~~ promotes skills for coping with and managing symptoms while utilizing natural supports and community resources. ~~and the preservation and enhancement of community living skills.~~

Peer Support Services (PSS) ~~are~~ is provided one-on-one to ~~the~~ a beneficiary or in a group setting. Providing one-on-one support builds on the relationship of mutuality between ~~the~~ a beneficiary and a CPSS, ~~;~~ supports ~~the~~ a beneficiary in accomplishing self-identified goals, ~~;~~ and may further support a ~~the~~ beneficiary's engagement in treatment. Peer Support Services provided in a group setting allow a ~~the~~ beneficiary the opportunity to engage in structured services with others that share similar recovery challenges or interests; improve or develop recovery skills; and explore community resources to assist a ~~the~~ beneficiary in ~~his or her~~ their recovery. PSS interventions are based on a ~~the~~ beneficiary's needs and goals and are coordinated within the context of ~~the~~ a beneficiary's Person-Centered Plan. Structured services provided by PSS include:

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a. **Peer mentoring or coaching (one-on-one)**: To encourage, motivate, and support beneficiary moving forward in recovery. Assist beneficiary with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.
b. **Recovery resource connecting**: To connect a beneficiary to professional and nonprofessional services and resources available in the community that can assist a beneficiary in meeting recovery goals.
c. **Skill Building Recovery groups**: Structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.
d. **Building community**: To ~~A~~assist a beneficiary in enhancing their ~~his or her~~ social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented services that provide a sense of acceptance and belonging to the community, promote learning of social skills and the opportunity to practice newly learned skills.

1.1 Definitions:

Recovery:
Recovery is a process of change through which a beneficiary improves their health and wellness, lives a self-directed life and strives to reach their full potential; to live, work, learn, and participate fully in their communities.

Self-Determination:
Self- Determination is the right of a beneficiary to direct his or her own services, to make decisions concerning their health and well-being, and to have help to make decisions from whomever they choose.

Self-Advocacy:
Self-Advocacy is the ability to identify and purposefully ask for what one needs.

Health:
Health is learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing.

Community:
Community is defined as relationships and social networks that provide support, friendship, love and hope.

Serious Mental Illness (SMI):
As defined by the Substance Abuse Mental Health Services Administration (SAMHSA), "SMI is defined by someone over 18 years of age having within the past year a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."

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Substance Use Disorder (SUD):
As defined by SAMHSA,"SUD is defined when the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Lived Experience:
Lived Experience is personal knowledge, awareness, and understanding gained through direct involvement in life events, particularly those related to mental health, substance use, and recovery.

Peer Modeling:
Peer Modeling is a demonstration of hope, resilience, and positive recovery behaviors by a CPSS to help a beneficiary in establishing or maintaining recovery.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

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

a. **Medicaid**

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

A retroactively eligible beneficiary is entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts~~.~~, ~~The qualified provider may file for reimbursement with Medicaid for these services.~~ provided that such filing meets Medicaid's claim submission requirements.

Medicaid shall cover Peer Support Services for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing*

Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

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

3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in clinical coverage Policy 1-H, Telehealth, *Virtual Patient 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 may be provided via the telephonic, audio-only communication method. Telephonic services may be transmitted between a beneficiary and provider in a manner that is consistent with the CPT and HCPCS code definition for those services.

Refer to **subsection 3.2.5.1** for **Telephonic-Specific Criteria**; and **subsection 7.1** for **Compliance** requirements.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover Peer Support Services when ALL following criteria are met:

a. The beneficiary has a ~~mental health~~ a serious mental illness as defined in **Section 1.1** or substance use disorder ~~diagnosis~~ as defined in **Section 1.1**, along with a corresponding diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition

(DSM-5) or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;

b. Beneficiary with a substance use diagnosis meets the American Society of Addiction Medicine (ASAM) Level 1 criteria;

c. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards.;

d. The beneficiary has documented identified recovery-oriented needs (related to diagnosis) in, at least ONE TWO or more of the following areas:, (related to diagnosis,):

1. Acquisition of self-advocacy skills to navigate the behavioral health system and access community resources;
2. Empowerment to take responsibility for their own recovery; and
3. Develop recovery skills to engage in and maintain recovery;

and

e. The beneficiary has documented rehabilitative recovery-oriented needs in at least ONE or more of the following areas (related to diagnosis):

1. Adaptive skills (communication, problem-solving, or organizational skills);
2. Employment or education to gain employment;
3. Maintain personal safety or mitigate self-harm risk;
4. Maintenance of active recovery from substance use, including for those receiving medication assisted treatment, and maintenance of relapse prevention skills.

1. Acquisition of to manage symptoms and utilize community resources ;
2. Assistance needed to develop self-advocacy skills to achieve decreased dependency on the mental health; and
3. Assistance and support needed to prepare for a successful work experience
4. Peer modeling needed to take increased responsibilities for his or her own recovery; or
5. Peer supports needed to develop or maintain daily living skills.

3.2.2 Admission Criteria

A comprehensive clinical assessment (CCA), that demonstrates medical necessity must be completed by a licensed clinician prior to the provision of this service. If an equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards and all applicable federal and state requirements, it may be used as part of the current CCA. Relevant clinical information must be obtained and documented in the beneficiary's Person-Centered Plan (PCP).

Refer to *Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers,* for CCA requirements including The American Society of Addiction Medicine 3rd edition, 2013 (ASAM) level of care determination for a beneficiary diagnosed with a substance use disorder.

3.2.3 Continued Stay Criteria

a. The beneficiary meets criteria for continued stay if any ONE of the following applies:
   1. The desired outcome or level of functioning is achievable with PSS but has not been restored, improved, or sustained over the time frame documented in ~~the~~ a beneficiary's PCP;
   2. The beneficiary has a ~~continues to be at~~ high risk for relapse or self-harm based on current clinical assessment or reassessment and PSS interventions are expected to reduce the high risk, ~~and history,~~ or the tenuous nature of the functional gains~~; or~~, or
   3. The beneficiary has been assessed for either a step-down to natural supports or a transition to more intensive clinical services; PSS remains the most clinically appropriate option at this time.; and
b. The beneficiary meets ONE of the following conditions:
   1. Has achieved current PCP goals but additional goals are indicated by a current assessment or reassessment;
   2. Continuation of service is supported by documentation of beneficiary's progress toward goals within the beneficiary's PCP; or
   3. The desired outcome or level of functioning is achievable with PSS but has not been restored and it is necessary to amend interventions in the beneficiary's PCP

3.2.4 Transition and Discharge Criteria

The beneficiary meets the criteria for discharge if any ONE of the following applies:

a. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan; ~~to step down to a lower level of care;~~
b. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services;
c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or
d. The beneficiary chooses to withdraw from Peer Support Services or the legally responsible person(s) chooses to withdraw the beneficiary from services.

Transition and discharge planning shall begin at admission and be documented in the service record. The discharge plan shall be developed in collaboration with the beneficiary and reviewed every 60 calendar days with Peer Support Service (PSS) Program Supervisor.

3.2.5 Medicaid Additional Criteria Covered

Telephonic-Specific Criteria:

a. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
b. Providers shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
c. The beneficiary's safety must be carefully considered for the complexity of the services provided;
d. 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 should also be considered;
e. Delivery of services using telephonic, audio-only communication must conform to professional standards of care: ~~including but not limited to~~ ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements such as ~~including~~ Practice Act and Licensing Board rules;
f. Providers shall obtain and document verbal or written consent~~.~~ from the beneficiary or their legally responsible person. In extenuating circumstances when consent is unable to be obtained, this should be documented;
g. Providers must verify the beneficiary's identity using two points of identification before initiating a telephonic, audio-only encounter; and,
h. Providers shall ensure that beneficiary privacy and confidentiality is protected.

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

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

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover the following activities for Peer Support Services:

a. Transportation for the beneficiary or family members;
b. Habilitation activities or goals;

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c. Time spent performing, attending or participating in recreational activities unless providing a structured intervention(s) as documented in a beneficiary's Person Centered Plan; ~~tied to specific planned social skill assistance;~~
d. Clinical and administrative supervision of the Peer Support Specialist which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;
f. Childcare services or services provided as a substitute for the parent or others ~~beneficiaries~~ responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified in the beneficiary's Person-Centered Plan;
i. Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's recovery needs and not listed on the Person-Centered Plan; ~~and~~
j. Payment for room and board~~.~~ ;and
k. Digital text-based messages via mobile device or internet applications and email correspondence.

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 Peer Support Services.~~
Medicaid shall require prior approval for Peer Support Services provided beyond the unmanaged unit limitation of twenty-four (24) units. A beneficiary is permitted unmanaged units once per episode of care. Refer to **Subsection 5.3** for additional limitations.

Prepaid Inpatient Health Plans (PIHPs) or Prepaid Health Plans (PHPs) that offer less restrictive limitations on unmanaged units than those established by NC Medicaid policy shall ensure that there are oversight protocols in place to prevent over-billing for services.

Providers shall obtain prior approval if they are uncertain that a beneficiary has reached the unmanaged unit limit for the fiscal year.

Providers shall collaborate with a beneficiary's existing mental health or substance use service provider, clinical home, care manager or care coordinator to develop an integrated plan of care.

Prior authorization is not a guarantee of claim payment.

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5.2 Prior Approval Requirements

5.2.1 General

~~None Apply.~~

The provider(s) shall submit to the PIHP or PHP the following:

a. the prior approval request; and

b. all relevant 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.~~

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.

Initial and Reauthorization Requirements

Services based upon a finding of medical necessity must be directly related to a beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's Person-Centered Plan (PCP). Medical necessity is determined by North Carolina community practice standards, as verified by the DHHS Utilization Management Review 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 efficacious as services requested by a 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 initial authorization, the CCA, service order for medical necessity, PCP, and the required NC Medicaid authorization request form must be submitted to the DHHS Utilization Management Review Contractor. Medicaid authorization is based on medical necessity documented on the authorization request form and supporting documents.

The duration and frequency at which PSS is provided must be based on medical necessity and progress made by a beneficiary toward goals outlined in the PCP. It is expected that service intensity titrates down as a beneficiary demonstrates improvement in recovery-oriented skills and in establishing natural and community supports to maintain recovery.

Medicaid may cover up to 176 units of PSS over a 60-calendar-day authorization period, not to exceed 88 units per 30-calendar-day period. Authorization requests for more than 88 units per 30-calendar-day period must be reviewed and reauthorized every 30 calendar days.

The DHHS Utilization Management Review Contractor may authorize medically necessary PSS at the clinically appropriate amount, duration, and frequency. Authorization timeframes and unit thresholds are intended to guide utilization

review frequency and do not limit authorization of medically necessary services supported by documentation.

When it is medically necessary for PSS to be authorized for more than nine months, a new CCA or an addendum to the original CCA and a new service order must be completed and submitted with the reauthorization request. Reauthorization requests beyond nine months must be reviewed and reauthorized every 30 calendar days.

Note: Any denial, reduction, suspension, or termination of PSS requires beneficiary or legally responsible person(s) of the beneficiary be notified of their appeal rights.

5.3 Additional Limitations or Requirements

a. A beneficiary can receive PSS from only one provider organization during an episode of care.
b. Family members or legally responsible person(s) of the beneficiary are not eligible to provide this service to the beneficiary.
c. A beneficiary with a sole diagnosis of Intellectual~~/~~Developmental Disabilities is not eligible for PSS funded by Medicaid.
d. PSS must not be provided to a beneficiary to address primary medical diagnosis not related to serious mental illness or substance use disorder recovery.
e. PSS must not be billed or provided to substitute or supplement staffing requirements of any facility-based service or be provided as a companion or supervision service.
f. ~~Peer Support~~ PSS must not be provided to a beneficiary receiving ~~during the same episode of care as~~ Assertive Community Treatment ~~Team~~ (ACT~~T~~), as a peer support specialist is a required position ~~requirement of~~ on the ACT ~~that~~ ~~t~~Team.
g. ~~Peer Support~~ PSS must not be provided to a beneficiary receiving ~~during the same episode of care as~~ Community Support Team (CST), as ~~a~~ peer support ~~specialist~~ may be a component of the service and a beneficiary who is in need of CST and peer support shall be offered CST providers who have peers on the team.
h. PSS must not be provided during the same time of day when a beneficiary is receiving Substance Abuse Intensive Outpatient Program (SAIOP) or Substance Abuse Comprehensive Outpatient Treatment (SACOT), Partial Hospitalization, Psychosocial Rehabilitation (PSR), Respite, or Individual and Transitional Support (ITS) services.
i. PSS must not be provided during the same time of day when a beneficiary is receiving Individual Placement and Support (IPS).
j. PSS must not be provided during the same episode of care as other Medicaid services with duplicative components. ~~duplicative of other Medicaid services the beneficiary is receiving.~~
k. Transportation of a beneficiary is not covered as a component for this policy. ~~Only the time the beneficiary is receiving interventions in the PCP may be billed to Medicaid.Any provision of services provided to a beneficiary during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided.~~ This limitation does not impact a beneficiary's ability to access non-emergency medical transportation (NEMT).

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l. PSS must not be provided to a beneficiary receiving Clinically Managed Population Specific High-Intensity Residential Program; Clinically Managed Residential Services; or Medically Monitored Intensive Inpatient Services.

Note: PSS is not a "first responder" service. The PSS provider shall coordinate with a beneficiary's health plan, clinical home, care manager, care coordinator or a crisis service provider to ensure crisis response services are accessible as documented in the beneficiary's PCP.
~~As documented in the beneficiary's PCP Comprehensive Prevention and Intervention Crisis Plan, the PSS provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response.~~

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A service order must be signed by a physician, physician assistant, nurse practitioner, licensed clinical mental health counselor, licensed clinical addiction specialist, licensed marriage and family therapist, licensed clinical social worker, or licensed psychologist ~~or other licensed clinician~~ per their ~~his or her~~ scope of practice, prior to or on the first day service is rendered. A clinician signing a service order for PSS must be licensed to practice independently.
ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
c. A service order must be in place prior to or on the first day that the service is initially provided to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid the provider shall not bill Medicaid without a valid service order; and
d. Service orders are valid for nine months ~~one calendar year~~. Medical necessity must be reviewed, and service must be ordered at least ~~annually~~ every nine months, based on the date of the original PCP service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for the staff member who provided the service. The PCP and a documented discharge plan must be discussed with the beneficiary and documented in the service record.

5.5.1 Contents of a Service Note

For this service, a full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must document ALL following elements:

a. Beneficiary's name;
b. Medicaid identification number;
c. Date of the service provision;

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d. Name of service provided;
e. Type of contact (in person, telehealth or telephonic, audio-only communication);
f. Place of service;
g. Purpose of contact as it relates to the PCP goals:
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent delivering ~~performing~~ the intervention(s), must include the start time and end time;
j. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

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

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Peer Support Services must be delivered by practitioners employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
b. meet the requirements of 10A NCAC 27G or equivalent federally recognized tribal code or federal regulation;
c. demonstrate they meet these standards by being credentialed and contracted by a Prepaid Health Plan or Prepaid Inpatient Health Plan, or the Cherokee Indian Hospital Authority;
d. within one calendar year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies; and
e. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards.

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6.2 Provider Certifications

PSS must be provided by a Peer Support Specialist certified by North Carolina's Certified Peer Support Specialist Program (NC CPSS Program). CPSS must maintain an active NC certification to provide services included in this policy. Providers of PSS shall maintain a roster of NC CPSS they employ to provide services included in this policy. Providers shall ensure the NC CPSS Roster is accessible and ready to share with their contracted PHP or PIHP upon request.

The roster must include at a minimum:

a. the full name of the NC CPSS;
b. date of hire;
c. date of initial certification;
d. date of recertification, when applicable; and
e. date of separation; when applicable

6.2.1 Staff Requirements

The Peer Support Services (PSS) program is provided by qualified providers with the capacity and adequate workforce to offer this service to an eligible Medicaid beneficiary. PSS must be available during times that meet the needs of the beneficiary which may include evenings, weekends, or both. The PSS program must be under the direction of a full-time Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104 ~~(19)~~ or equivalent federally recognized tribal code or federal regulation.

The PSS program must have designated competent mental health or substance use professionals to provide supervision to CPSS during the times of service provision.

The maximum program staff ratios are as follows: QP-to-CPSS is 1:8; CPSS-to-beneficiary is 1:15; and group ratio for CPSS Group Facilitator-to-a beneficiary is 1:12.

~~The PSS program must follow the NC Peer Support Specialist Code of Ethics and Values and principles when rendering PSS services. All ethical issues must be governed by the administrators of the Peer Support Specialist Registry and policies and procedures established by the hiring provider agency.~~

CPSS shall not work outside the scope of their certification or core competencies. CPSS shall only provide services to a beneficiary with similar lived experiences.

The following charts provide required services of the PSS Program Supervisor and core competencies of relationship building and peer support interaction for the CPSS (according to NC's Certified Peer Support Specialist Program).

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Peer Support Services Program Supervisor
• Trained in quality supervisory skills. • Understand and promote adherence to the NC Certified Peer Support Specialist Program Code of Ethics and Conduct. • Possesses knowledge of the CPSS role and work, as well as understand the principles and philosophy of recovery. and the code of ethics of the NC Peer Support Specialist Certification Program. • Understand and support the role of the CPSS. to ensure the CPSS works within their scope. • Understand and promote the each beneficiary's recovery. • Advocate for the CPSS and PSS across the organization and in the community. • Promote both the professional and personal growth of the CPSS within established human resource standards. • Coordinate assessments needed for the beneficiary. If appropriately licensed, the QP may conduct the assessments. within their scope of practice. • Collaborate with each beneficiary(s) and CPSS to develop a recovery-oriented person-centered plan for the beneficiary that demonstrates consideration for integrated care. • Conduct at least one in-person, telehealth,or telephonic, audio-only communication contact with each the beneficiary within 60 calendar 90 days of PSS being initiated and no less that than every 60 calendar 90 days thereafter to monitor the beneficiary's progress and effectiveness of the program; and to review with the beneficiary the goals of their PCP, review transition and discharge plan and document progress. • Plan work assignments, monitors, reviews, and evaluates work performance of program staff and facilitates staff meetings and conducts routine reviews of service notes for quality assurance. • Provide administrative and supportive supervision to program staff individually at least once per month every other week or more if needed. Provision of supervision must be based on the experience of the individual staff. • Collaborate with program staff to assess strengths and areas of growth and develop an individual supervision plan. • Collaborate and foster collegial roles with program staff. • Determine team caseload size based on the level of acuity and needs of the beneficiary(s). • Facilitate or co-facilitate skill building recovery groups based on the needs or request of the beneficiary. • Ensure referrals for community resources requested by each beneficiary(s) are completed.

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Certified Peer Support Specialist
• Knowledge and adherence to ~~of~~ peer support principles, values, and ethics. • ~~Ability to~~ ~~s~~Share lived experience to support, encourage and enhance a beneficiary's treatment and recovery. • Possess recovery-oriented skills and knowledge to provide peer support services. • ~~Ability to~~ ~~c~~Collaborate with the program QP to assess their own strengths and areas of growth and develop an individual supervision plan. • ~~Ability to collaborate with a beneficiary to~~ ~~e~~Explore and identify barriers to accessing community resources or treatment providers with a beneficiary. • ~~Ability to~~ ~~m~~Model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for the beneficiary served and to promote a recovery environment in ~~the~~ their community, residence, and workplace. • Collaborate with a beneficiary in identifying their strengths; establishing recovery goals and short-term objectives that reflect the beneficiary's preferences and encourage self-determination. • Model the use of self-directed recovery tools, such as Wellness Recovery Action Planning (WRAP), and empower utilization of tools by a beneficiary. • ~~Ability to~~ ~~e~~Explore with a beneficiary served, the importance and creation of a wellness identity through open sharing and challenging viewpoints. • ~~Ability to promote a beneficiary's opportunity for personal growth by identifying~~ Identify teachable moments for building relationship skills to empower the beneficiary and enhance personal responsibility ~~and growth~~. • ~~Ability to~~ ~~m~~Model and share decisions-making tools to enhance a beneficiary's healthy decision-making process. • ~~Ability to~~ ~~p~~Provide examples of healthy social interactions and facilitate familiarity with, and connection to, the local community. • ~~Ability to~~ ~~r~~Recognize and appropriately respond to conditions that constitute an emergency to include both physical and behavioral health crisis utilizing the emergency response procedure of employer. • ~~Ability to provide support to the~~ Educate and coach a beneficiary in navigating systems (medical, social services, or legal). • ~~Ability to~~ ~~p~~Promote self-advocacy and empowerment by facilitating each beneficiary's learning about ~~his or her~~ their-human and legal rights and supporting ~~the~~ a beneficiary while exercising those rights ~~to support the empowerment of the beneficiary~~. • Collaborate with program QP and a beneficiary after discharge from a mental health or substance use disorder crisis service to review recovery tools and strategies for crisis prevention; and update the crisis plan. • Explore and identify challenges of transitioning to the community from an incarceration or institutional stay with a beneficiary to develop strategies to maintain recovery in the community. • Collaborate with the beneficiary's health plan, clinical home, care manager, care coordinator or other service provider(s) to support a beneficiary's recovery.

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6.2.2 Training Requirements

To provide effective peer support services, all PSS program staff shall possess the knowledge and competencies of peer support principles, values and ethics and participate in additional trainings required to provide the service. Required trainings for PSS program staff are as follows:

Timeframe	Training Required	Who	~~Total Minimum Hours Required~~
Within **30 calendar days** of hire to provide service	• ~~3 hours of~~ Peer Support Services Policy components review • ~~1 hour of~~ Documentation Training • Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose)	• All staff	~~4 hours~~
	• NC Peer Support Supervisor Training	• Peer Support Services Program Supervisor	
Within ~~90~~ **60 calendar days** of hire to provide service	• ~~3 hours of Peer Support Supervisor Training~~ • ~~12 hours of~~ Person-Centered Thinking • ~~3 hours of~~ PCP Instructional Elements with Comprehensive Prevention and Intervention Crisis Plan Training	• Peer Support Services Program Supervisor	~~18 hours~~
Annually	• Continuing education related to the population being served.	All staff	~~10 hours~~

Peer support program staff shall complete initial requirements of training identified above within identified timeframes. The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training was completed no more than 24-months prior to hire date.

Peer support program staff shall participate in additional hours of peer support related training that is appropriate for the population being served. Additional training options for all PSS program staff include:

a. Trauma Informed Care;

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b. Wellness and Recovery Action Plan (WRAP);
c. Whole Health Action Management (WHAM);
d. Basic Mental Health and Substance Use 101;
e. Mental Health First Aid; and
f. Housing First, Permanent Supportive Housing, Tenancy Support Training.

6.3 Program Requirements

PSS is not a replacement for clinical care, but rather a complementary service that enhances the effectiveness of other mental health and substance use services. PSS work best when integrated into a broader, coordinated care system. The PSS program shall be integrated within a provider organization that offers, at minimum, comprehensive clinical assessment (CCA), psychotherapy and medication management.

If the integrated PSS provider organization does not offer medication management, the provider shall partner with a medication management provider with a signed Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA).

Existing providers of PSS must establish a signed MOU or MOA within 90 calendar days of the amended effective date of this policy. Providers enrolling in Medicaid to provide PSS on or after the amended effective date of this policy must establish a signed MOU or MOA prior to providing PSS. The signed MOU or MOA must be submitted by the PSS provider to its contracted health plan(s).

The integration of the PSS program with other clinical services and the MOU or MOA is an assurance that a beneficiary receiving PSS shall have access to medically necessary clinical services to enhance recovery and improve quality of life for a beneficiary with a serious mental illness or substance use disorder diagnosis. A beneficiary shall be given a choice of providers to receive integrated mental health and substance use services. The beneficiary is not required to obtain mental health, substance use, or medication management services from the integrated PSS provider organization or from providers identified through the MOU or MOA.

Providers of PSS shall link a beneficiary to needed mental health services within 14 calendar days and to needed substance use services within 72 hours of identifying a routine need. Identified urgent and emergent needs should be immediately addressed through a referral to the appropriate clinical or crisis provider. The PSS provider shall collaborate with the beneficiary's care manager, when applicable.

To maintain the integrity of the PSS program, provider agencies shall have policies that address the practice of CPSS providing PSS to employees within the agency. These policies shall include safeguards to prevent conflicts of interest, dual relationships, and breaches of professional boundaries. Safeguards must include at minimum, ALL the following:

a. CPSS shall not provide PSS to individuals who serve as their direct supervisors, managers, or individuals who influence their employment status;
b. Whenever possible, CPSS shall not provide PSS to coworkers within their own program area, work unit, or team to avoid dual relationships;

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c. If providing PSS to a coworker within the CPSS's program area, work unit or team is unavoidable or clinically appropriate, the assignment must be reviewed and approved by program leadership prior to the first day service is rendered;
d. A conflict-of-interest assessment shall be completed and documented before PSS begins, outlining identified risks and the steps to mitigate them;
e. Employees receiving PSS shall be informed in writing of the limits of confidentiality as they apply within an employment setting;
f. Supervisors of CPSS must provide ongoing monitoring to ensure boundaries are maintained and no adverse impact occurs on workplace relationships or performance.
g. CPSS may request reassignment of a case if they believe their objectivity; boundaries, or personal well-being may be compromised; and
h. Any suspected boundary concerns must be reported according to agency policy and reviewed promptly to determine appropriate action.

These safeguards ensure the PSS program maintains ethical standards, protects the well-being of both employees and CPSS, and preserves the integrity of the peer support relationship.

The PSS program shall adhere to the NC Certified Peer Support Specialist Program Code of Ethics and Conduct and principles when rendering PSS services. All relevant ethical issues must be reported to the NC CPSS Program and addressed under policies and procedures established by the hiring provider agency.

Providers of PSS are responsible for verifying CPSS providing the services in this policy are certified by the NC CPSS Program. Providers are required to:
a. Verify NC CPSS certification at the time of hire via the NC Certified Peer Support Specialist Program website;
b. Request and maintain a copy of the employee's active NC CPSS certificate in the employee's record;
c. Restrict CPSS from providing services when NC CPSS certification is expired or has been revoked; and
d. Report violations of the NC CPSS Program Code of Ethics and Conduct

6.4 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the beneficiary's PCP.
Expected outcomes:
a. increased engagement in self-directed recovery process;
b. increased natural and social support networks;
c. increased ability to engage in community activities;
d. increased ability to live independently as possible and use recovery skills to maintain a stable living arrangement;
e. higher levels of empowerment and hopefulness in recovery;
f. improved emotional, behavioral, and physical health;
g. improved quality of life;
h. improved vocational skills;
i. decreased substance use;
j. decreased frequency or intensity of crisis episodes; or
k. decreased use of crisis services or hospitalizations.

7.0 Additional Requirements

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

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

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

Note: Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with federal laws and regulations.

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8.0 Policy Implementation and History

Original Effective Date: November 01, 2019

History:

Date	Section or Subsection Amended	Change
11/01/2019	All Sections and Attachment(s)	New policy implementing Peer Support Services.
11/01/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
12/12/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/01/2020	Related Clinical Coverage Policies	1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring
12/01/2020	Subsection 3.1.1	Added new subsection 3.1.1 Telehealth Services.
12/01/2020	Subsection 3.1.2	Added new subsection 3.1.2 Telephonic Services
12/01/2020	Subsection 3.2.5.1	Added new subsection 3.2.5.1 Telephonic Specific-Criteria
12/01/2020	Subsection 5.5.1	Updated policy language. Deleted: "face-to face, phone". Added: "in person, telehealth or telephonic, audio-only communication".
12/01/2020	Subsection 6.2.1	Updated policy language. Deleted: "face-to-face" and "telephone". Added: "in-person, telehealth or telephonic, audio-only communication".
12/01/2020	Attachment A, letter C	Added columns to service codes indicating if the services were eligible for telehealth and telephonic, audio-only communication. Added "Note: Telehealth and telephonic, audio-only communication eligible services may be provided to both new and established patients by the eligible providers listed within this policy."
12/01/2020	Attachment A, Letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for 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.

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Date	Section or Subsection Amended	Change
12/01/2020	Attachment A, Letter F	Deleted: "telephone" and "face-to-face". Added: "telehealth or telephonic, audio-only" and "in-person". Added language: Telehealth and telephonic, audio-only communication claims should be filed with the provider's usual place of service code(s).
12/01/2020	Added beginning of Policy	Added the language "This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect."
08/15/2022	Subsection 3.2.1, Letter b.	Technical change: deleted "the Level of Care criteria for Locus Level 1".
08/15/2022	Subsection 3.2.4, Letter b.	Technical change: separated criterion b. into two separate criteria.
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.
12/15/2023		Removed the language "This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect." Posting date and Amended date not changed
01/01/2025	Subsection 4.2.1	Removed l". Services provided without prior authorization;".
01/01/2025	Section 5.0	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, unmanaged unit limit and language referencing prior approval, authorizations, initial authorizations, reauthorizations, and utilization management have been removed.
01/01/2025	Subsection 5.3	"Episode of care" replaced "active authorization period". Removed "The beneficiary may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period."
01/01/2025	Attachment A: Claims-Related Information	Added: 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.
01/01/2025	Attachment A: Claims-Related Information, E. Billing Units	Added: Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

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Date	Section or Subsection Amended	Change
00/00/0000	Section 1.0	"Serious Mental Illness" replaced "mental health" diagnosis.
00/00/0000	Subsection 1.1.7	Added definitions for Serious Mental Illness, Substance Use Disorder, Lived Experience, and Peer Modeling
00/00/0000	Subsection 2.1.2	"Provided that such filing meets Medicaid's claim submission requirements" replaced "the qualified provider may file for reimbursement with Medicaid for these services."
00/00/0000	Section 3.0	Revised specific criteria covered by Medicaid, continued stay criteria, and transition and discharge criteria.
00/00/0000	Subsection 3.2.1	a."Serious mental illness" diagnosis replaced "mental health" diagnosis. b. Removed American Society of Addiction Medicine (ASAM) Level 1criteria. d. "Recovery-oriented" needs replaced "identified" needs. "At least ONE or more replaced with "at least TWO or more" Replaced d 1. "Acquisition of skills to manage symptoms and utilize community resources with "Acquisition of self-advocacy skills to navigate the behavioral health system and access community resources." Replaced d 2. "Assistance needed to develop self-advocacy skills to achieve decreased dependency on the mental health with "Empowerment to take responsibility for their own recovery." Removed d.3 "Assistance and support needed to prepare for a successful work experience." Replaced d.4 "Peer modeling needed to take increased responsibilities for his or her own recovery and d.5. Peer supports needed to develop or maintain daily living skills" with d.3. "Develop recovery skills to engage in and maintain recovery." Added e. "The beneficiary has documented rehabilitative recovery-oriented needs in at least ONE or more of the following areas (related to diagnosis)." Added e.1. "Adaptive skills (communication, problem-solving, or organizational skills)." Added e.2. "Employment or education to gain employment." Added e.3. "Maintain personal safety or mitigate self-harm risk." Added e.4 "Maintenance of active recovery from substance use, including for those receiving medication assisted treatment, and maintenance of relapse prevention skills."

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Date	Section or Subsection Amended	Change
00/00/0000	Subsection 3.2.2	Added reference to *Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, for Comprehensive Clinical Assessment requirements.
00/00/0000	Subsection 3.2.3	a. Added "is achievable with PSS but" b. Added "high", "self-harm" and language "or assessment and PSS interventions are expected to reduce the high risk" c. Added "The beneficiary has been assessed for either a step-down to natural supports or a transition to more intensive clinical services; PSS continues to be the appropriate service and support; and The beneficiary meets ONE of the following conditions: 1. Has achieved current PCP goals but additional goals are indicated by a current assessment or reassessment; 2. Continuation of service is supported by documentation of beneficiary's progress toward goals within the beneficiary's PCP. 3. The desired outcome or level of functioning is achievable with PSS but has not been restored and it is necessary to amend interventions in the beneficiary's PCP"
00/00/0000	Subsection 3.2.4	Removed "to step down to a lower level of care;" Added "Transition and discharge planning shall begin at admission and be documented in the service record. The discharge plan shall be developed in collaboration with the beneficiary and reviewed every 60 calendar days with Peer Support Service (PSS) Program Supervisor."
00/00/0000	Subsection 3.2.5	d. Removed "via telehealth" f. Added "from the beneficiary or their legally responsible person."
00/00/0000	Subsection 4.2.1	b. Added "or goals;" c. "Providing a structured intervention(s) as documented in a beneficiary's Person-Centered Plan; replaced "tied to specific planned social skill assistance;" f. Removed "beneficiaries" i. Added "recovery" Added (k) "Digital text-based messages via mobile device or internet applications and email correspondence."
00/00/0000	Section 5.0	Added unmanaged units and prior approval, authorizations, initial and reauthorization requirements.

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Date	Section or Subsection Amended	Change
00/00/0000	Subsection 5.3	Updated acronyms "PSS" for Peer Support, "PSR" for Psychosocial Rehabilitation Removed "Team" from Assertive Community Treatment and updated acronym to "ACT" d. Added "PSS must not be provided to a beneficiary to address primary medical diagnosis not related to serious mental illness or substance use disorder recovery." e. Added "PSS must not be billed or provided to substitute or supplement staffing requirements of any facility-based service or be provided as a companion or supervision service." f. "To a beneficiary receiving" replaced "during the same episode of care" and "required position" replaced "requirement" g. "To a beneficiary receiving" replaced "during the same episode of care" h. Individual and Transitional Support (ITS) replaced Individual Support i. Added "PSS must not be provided during the same time of day when a beneficiary is receiving Individual Placement and Support (IPS)." j. "provided during the same episode of care as other Medicaid services with duplicative components" replaced "duplicative of other Medicaid services the beneficiary is receiving." k. Removed "Only the time the beneficiary is receiving interventions in the PCP may be billed to Medicaid. Any provision of services provided to a beneficiary during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided." l. Added "PSS must not be provided to a beneficiary receiving Clinically Managed Population Specific High-Intensity Residential Program; Clinically Managed Residential Services; or Medically Monitored Intensive Inpatient Services." Added to Note, "The PSS provider shall coordinate with a beneficiary's health plan, clinical home, care manager, care coordinator or a crisis service provider to ensure crisis response services are accessible as documented in the beneficiary's PCP." Removed "As documented in the beneficiary's PCP Comprehensive Prevention and Intervention Crisis Plan, the PSS provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response."

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Date	Section or Subsection Amended	Change
00/00/0000	Subsection 5.4	"Physician assistant, nurse practitioner, licensed clinical mental health counselor, licensed clinical addiction specialist, licensed marriage and family therapist, licensed clinical social worker, or licensed psychologist per their scope" replaced "or other licensed clinician "
00/00/0000	Subsection 5.5.1	i. "Delivering" replaced "performing" and added "intervention(s), must include the start time and end time."
00/00/0000	Section 6.0	Added provider certification requirements, revisions to staff requirements, staff training requirements, and program requirements
00/00/0000	Subsection 6.1	b. Added "or equivalent federally recognized tribal code or federal regulation"
00/00/0000	Subsection 6.2	Revised peer support program name to include "certified" and added acronym "NC CPSS program." Added "CPSS must maintain an active NC certification to provide services included in this policy." Added "Providers of PSS shall maintain a roster of NC CPSS they employ to provide services included in this policy. The roster must include at a minimum: a. the full name of the NC CPSS; b. date of hire; c. date of initial certification; d. date of recertification, when applicable; and e. date of separation; when applicable" Added "Providers shall ensure the NC CPSS Roster is accessible and ready to share with their contracted PHP or PIHP upon request."

00/00/0000	Subsection 6.2.1	"10A NCAC 27G .0104" replaced "10A NCAC 27G .0104 (19) or equivalent federally recognized tribal code or federal regulation." Removed "The PSS program must follow the NC Peer Support Specialist Code of Ethics and Values and principles when rendering PSS services. All ethical issues must be governed by the administrators of the Peer Support Specialist Registry and policies and procedures established by the hiring provider agency." Updated Peer Support Services Program Supervisor responsibilities: Added "Understand and promote adherence to the NC Certified Peer Support Specialist Program Code of Ethics and Conduct." Added "ensure the CPSS works within their scope." Added "licensed QP may work within their scope. QP progress monitoring revised to "60 calendar days" from "90 calendar days." Added "review transition and discharge plan" to QP responsibilities CPSS supervision requirement revised to "every other week" from "at least once per month." Updated Certified Peer Support Specialist responsibilities: Added "adherence to" peer support principles, values, and ethics. Removed "ability to" replaced with "collaborate, model, explore, provide, recognize and promote." Added "Collaborate with a beneficiary in identifying their strengths; establishing recovery goals and short-term objectives that reflect the beneficiary's preferences and encourage self-determination." Added "Model the use of self-directed recovery tools, such as Wellness Recovery Action Planning (WRAP), and empower utilization of tools by a beneficiary." Added "Collaborate with program QP and a beneficiary after discharge from a mental health or substance use disorder crisis service to review recovery tools and strategies for crisis prevention; and update the crisis plan." Added "Explore and identify challenges of transitioning to the community from an incarceration or institutional stay with a beneficiary to develop strategies to maintain recovery in the community". Added "Collaborate with the beneficiary's health plan, clinical home, care manager, care coordinator or other service provider(s) to support a beneficiary's recovery."

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Date	Section or Subsection Amended	Change
00/00/0000	Subsection 6.2.2	Removed minimum training hours Added training Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose) for all staff Revised timeframe for NC Peer Support Supervisor Training to 30 days of hired from 90 days of hire. Revised timeframe for Person-Centered Thinking, and PCP Instructional Elements Comprehensive Prevention and Intervention Crisis Plan Training to 60 calendar days of hire from 90 calendar days of hire. Added "related to the population served" to annual training requirement.
00/00/0000	Subsection 6.3	Added Program Requirements
00/00/0000	Section 7.1	Added "Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with federal laws and regulations."
00/00/0000	Attachment A	E. Added "Only services provided by NC Certified Peer Support Specialist may be billed. Services and supervision provided by Peer Support Program Supervisor is covered as an indirect cost and therefore must not be billed separately." F. Telehealth or telephonic, audio-only communication limited to "ten" percent from "twenty" percent.

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)

Institutional (UB-04/837I transaction)

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

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

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

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	Billing Unit	Telehealth Eligible	Telephonic Eligible
H0038	1 unit = 15 - minutes	Yes	Yes
H0038 HQ	1 unit = 15 - minutes	No	No

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

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

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 code(s) used which determines the billing unit(s).

Units are billed in 15-increments.

Only services provided by NC Certified Peer Support Specialist may be billed. Services and supervision provided by Peer Support Program Supervisor is covered as an indirect cost and therefore must not be billed separately.

PHPs, PIHPs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. PHPs and PIHPs shall assess their PSS network providers' adherence to service guidelines to assure quality services for the beneficiary.

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

F. Place of Service

PSS is a direct periodic service provided in a range of community settings. It may be provided in the beneficiary's place of residence, community, in an emergency department, or in an office setting. It may not be provided in the residence of PSS staff.

The intent of the service is to be community-based rather than office-based. Service may be provided via telehealth or telephonic, audio-only communication. Telehealth or telephonic, audio-only communication time is supplemental rather than a replacement of in-person contacts and is limited to ~~twenty (20)~~ ten percent or less of total service time provided per beneficiary per fiscal year. Documentation of service rendered via telehealth or telephonic, audio-only communication with the beneficiary or collateral contacts (assisting beneficiary with rehabilitation goals) must be documented according to **Subsection 5.5** of this policy.

Telehealth and telephonic, audio-only communication claims should be filed with the provider's usual place of service code(s).

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

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