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**NC Division of Medical Assistance
Mental Health Drug Management
Program Administrative Procedures**

**Medicaid and Health Choice
Clinical Coverage Policy No: 9C
Amended Date: October 1, 2015
Termination Date:**

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1.0—Description of the Procedure, Product, or Service

This policy applies to clinical criteria considered for prescriber peer to peer consultations. Peer to peer consultations shall result when selected prescribers are identified as having a pattern of prescribing medications for the treatment of a mental illness outside of established best practice guidelines. The peer to peer consultation will target inefficient, ineffective, or potentially harmful prescribing patterns.

1.1—Definitions

None Apply.

2.0—Eligibility Requirements

2.1—Provisions

2.1.1—General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 - 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 - 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2—Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. Medicaid
None Apply.
- b. NCHC
None Apply.

~~2.2 — Special Provisions~~

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

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

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

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

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

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

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

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

~~b. — EPSDT and Prior Approval Requirements~~

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

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

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

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

~~2.2.2~~ EPSDT does not apply to NCHC beneficiaries

~~2.2.3~~ Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

~~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 and NCHC 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.~~

~~3.2~~ Specific Criteria Covered

~~3.2.1~~ Specific criteria covered by both Medicaid and NCHC

None Apply.

~~3.2.2~~ Medicaid Additional Criteria Covered

None Apply.

~~3.2.3~~ NCHC Additional Criteria Covered

None Apply.

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

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

~~4.1 — General Criteria Not Covered~~

Medicaid and NCHC 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 both Medicaid and NCHC~~

~~None Apply.~~

~~4.2.2 — Medicaid Additional Criteria Not Covered~~

~~None Apply.~~

~~4.2.3 — NCHC Additional Criteria Not Covered~~

- ~~a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 - ~~1. No services for long term care.~~
 - ~~2. No nonemergency medical transportation.~~
 - ~~3. No EPSDT.~~
 - ~~4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."~~~~

~~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 and NCHC shall not require prior approval for Mental Health Drug Management Program Administration Procedures.~~

~~5.2 — Prior Approval Requirements~~

~~5.2.1 — General~~

~~None Apply.~~

~~5.2.2 Specific~~

~~None Apply. Peer to Peer Consultation Guidelines~~

~~5.2.3 Identification of a Prescriber for Peer-to-Peer Consultation~~

~~The Chief Medical Officer for the Division of Medical Assistance (DMA) and the Chief of Clinical Policy for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall require a peer to peer consultation with a targeted prescriber if:~~

- ~~a. the prescriber prescribes medication for a Medicaid or NCHC beneficiary for the treatment of mental illness, including but not limited to schizophrenia, bipolar disorder, or major depressive disorder; and~~
- ~~b. the prescriber is identified to have a prescribing pattern that includes prescribing three or more psychotropic medications concurrently for Medicaid or NCHC beneficiaries 18 years of age and under.~~

~~Identification Priority~~

~~The prescriber of medication for a Medicaid beneficiary less than 12 years of age or NCHC beneficiary less than 12 years of age shall be the priority if a hierarchical ranking for consultation is required.~~

~~5.2.4 Information Sources to Develop Criteria~~

~~Alternatives recommended during the peer to peer consultation shall be based upon available evidence based criteria regarding efficacy or safety of covered treatments.~~

~~5.2.5 Clinical Criteria for Alternatives Discussed in the Peer-to-Peer Consultation~~

~~Alternatives discussed during the peer to peer consultation may include~~

- ~~a. Evaluation of psychosocial, support, and family therapies in addition to pharmacological interventions.~~
- ~~b. Review of the assessment and diagnosis for the beneficiary when changing therapy or adding additional medication in the case of poor response~~
- ~~c. Consideration of the most effective medication for diagnosis to initiate treatment; optimization of therapeutic dose before changing or adding medications.~~
- ~~d. Consultation with expert child psychiatrist.~~
- ~~e. Determination of whether a recent inpatient stay affected the drug regimen in question (if so, document, at a minimum, the inpatient institution from which the patient was discharged).~~

~~5.2.6 Criteria Review~~

~~The criteria used for the peer to peer consultation will be reviewed at least every two years to keep current with available evidence based criteria regarding efficacy and safety of treatments used for mental illnesses, including schizophrenia, bipolar disorder, and major depressive disorder.~~

~~5.2.7 Decision Making Authority~~

~~The targeted prescriber has final decision-making authority to determine which prescription drugs to prescribe or refill.~~

~~**Note:** Although clinical information in the Behavioral Pharmacy Management packet sent to selected prescribers is available for the peer-to-peer consult, the peer-to-peer consultation does not discuss specific cases or make specific recommendations.~~

~~5.2.8 Failure to Participate in the Peer-to-Peer Consultation~~

~~A peer-to-peer consultation shall be conducted by telephone. Targeted prescribers are encouraged to voluntarily participate in the consultation. After three unsuccessful attempts to contact the prescriber by telephone for a peer-to-peer consultation, the prescriber will be sent written correspondence to establish communication. Prescribers who do not respond to verbal or written attempts at communication regarding a peer-to-peer consultation may incur temporary suspension of Medicaid and Health Choice payments until the consultation has occurred.~~

~~5.2.9 Ongoing Monitoring of Peer-to-Peer Consultation Effects~~

~~Each quarter, DMA will review utilization of medications prescribed for Medicaid and NCHC beneficiaries for the treatment of mental illness—including, but not limited to medications for schizophrenia, bipolar disorder, or major depressive disorder—to monitor outcomes from the peer-to-peer consultations. Summary findings and reports from peer-to-peer consultations will be shared with the N.C. Psychiatric Association, the N.C. Council of Child and Adolescent Psychiatry, and other appropriate specialty societies and subcommittees that are affected or can influence prescribing behaviors.~~

~~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 or NCHC 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~~

~~None Apply.~~

~~6.2 Provider Certifications~~

~~None Apply.~~

7.0—Additional Requirements

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

7.1—Compliance

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

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA'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).

8.0—Policy Implementation/Revision Information

Original Effective Date: October 1, 2008

Revision Information:

Date	Section Revised	Change
10/01/2008	Throughout	Medicaid General Coverage policy posted
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/12/2012	Throughout	Policy number changed from A5 to 9C to be equivalent where applicable to NC DMA's Clinical Coverage Policy # 9C under Session Law 2011-145, § 10.41.(b)
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2012	Subsection 2.3	Changed patient to beneficiary
07/01/2012	Throughout	Changed recipient to beneficiary and recipients to beneficiaries.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
	Entire Policy	Policy procedures for peer to peer consults obsolete and no longer operational.

~~Attachment A: Claims-Related Information~~

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

~~-~~

~~A. Claim Type~~

~~Does not apply~~

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

~~Does not apply~~

~~C. Code(s)~~

~~Does not apply~~

~~D. Modifiers~~

~~Does not apply~~

~~E. Billing Units~~

~~Does not apply~~

~~F. Place of Service~~

~~Does not apply~~

~~G. Co-payments~~

~~Does not apply~~

~~H. Reimbursement~~

~~Does not apply~~