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**NC Division of Medical Assistance
Services for Individuals with
Intellectual and Developmental
Disabilities and Mental Health or Substance
Abuse Co-Occurring Disorders**

**Medicaid and Health Choice
Clinical Coverage Policy No: 8-O
Amended Date: October 1, 2015**

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Related Clinical Coverage Policies

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:

8A, *Enhanced Mental Health and Substance Abuse Services*

8B, *Inpatient Behavioral Health Services*

8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*

8D-1, *Psychiatric Residential Treatment Facilities for Children under the Age of 21*

8D-2, *Residential Treatment Services*

8E, *Intermediate Care Facilities for Individuals with Intellectual Disabilities*

8I, *Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population*

8J, *Children's Developmental Service Agencies*

8L, *Mental Health/Substance Abuse Targeted Case Management*

8P, *North Carolina Innovations*

1.0 Description of the Procedure, Product, or Service

Individuals with intellectual and developmental disabilities and mental health or substance abuse co-occurring disorders may require integration of the disorders with respect to specific and focused respite/acute stabilization activities. Respite is available only for those beneficiaries on a Community Alternatives Waiver.

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.nctracks.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

Refer to DMA's clinical coverage policies 8A through 8P, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for the specific criteria for services referenced in this policy.

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. NCHC beneficiaries are not eligible for enrollment in a Community Alternative Program and are therefore not eligible for respite services.
- b. 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.”
Note: Subsection 4.2.3(b) applies to NCHC only.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for services referenced in this policy. The provider shall obtain prior approval before rendering services referenced in this policy.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor or the beneficiary’s Behavioral Health Pre-Paid Inpatient Health Plan (PHIP) the following:

- a. the prior approval request;
- b. all health records and any other records that are required for the prior authorization of the specific service being requested to support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

None Apply.

5.3 General Service Requirements

Services provided to individuals with intellectual and developmental disabilities and mental health or substance abuse co-occurring disorders are subject to the requirements and limits specific to the service or procedure they are receiving. Services may be provided in the settings indicated in the policy for the specific service or procedure that the beneficiary is receiving. Refer to the individual clinical coverage policies, on DMA’s Web site at <http://www.ncdhhs.gov/dma/mp/>, for service-specific information.

5.4 Assessment

The assessment should focus on defining the relationship between disruptive behaviors and responses to a range of physiological changes, environmental events, or personnel changes. The assessment should be consistent with the requirements of the Diagnostic Assessment service or other federally mandated requirements. It should be administered and interpreted by qualified disability specific and clinically appropriate professionals.

5.5 Person-Centered Plans

The Person-Centered Plan (PCP) shall be directed toward the acquisition of the following:

- a. behaviors necessary for the individual to function with as much self determination and independence as possible;

- b. prevention or deceleration of regression or loss of current optimal functional status;
- c. improvement in target behaviors or psychiatric symptoms (including but not limited to DSM-5, or any subsequent editions of this reference material, criteria) should be addressed. Monitors for symptomatic or behavioral improvement and a review of medication side effects are included in the PCP; and
- d. the PCP should include both behavioral interventions and the parameters for psychotropic drug use. If pharmacotherapy is used in the PCP, appropriate monitors should include a review of side effects and other adverse events that may affect quality of life or cognitive functioning.

5.6 Treatment

Mental illness and substance abuse behaviors can be a primary cause of behavioral regression, and a substantial impediment to effective behavioral interventions. For individuals with intellectual or developmental disabilities and mental health/substance abuse co-occurring disorders, treatment is defined as an initial biopsychosocial assessment (i.e., behavioral, psychiatric, maladaptive behaviors, and biomedical issues) and the development and implementation of an individual person-centered plan (PCP) that focuses on relieving target symptoms and core features of their disorder(s).

5.7 Reviews and Reassessments

Beneficiaries with intellectual or developmental disabilities and mental health or substance abuse co-occurring disorders may require specialized services that are established in the initial assessment and documented in the PCP. Since many psychiatric illnesses and /or maladaptive or behavioral disorders have a finite duration, appropriate review and reassessment by qualified treatment team members should occur at 3-month intervals. The results of this review should be made available to the beneficiary, their legal representative, and treatment team members.

5.8 Psychotropic Drugs

For beneficiaries with intellectual or developmental disabilities and mental health or substance abuse co-occurring disorders, all psychotropic drugs shall be reviewed within 30 calendar days of admission and at a minimum of 3-month intervals thereafter by a multidisciplinary team including at a minimum a physician and pharmacist.

Reviews include type of medication, evidence for effectiveness for the psychiatric disorder, monitors for medication side effects, and operationalized symptom monitors to measure improvements. Subsequent to this assessment, review of the PCP and medication should occur at 3-month intervals.

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 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 Medicaid Beneficiaries 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: July 1, 2006

Revision Information:

Date	Section Revised	Change
07/01/2003	Throughout	Administrative policy.
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	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 8-O under Session Law 2011-145, § 10.41.(b)
03/12/2012	Throughout	Replace the words "mental retardation" with "intellectual disability"
03/12/2012	Throughout	Policy number changed from A4 to 8-O
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
08/01/2014	All Sections and Attachments	Updated policy template language as needed.
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	Subsection 5.5	Changed DSM IV to DSM 5.
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.

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

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, 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.

Unlisted Procedure or Service

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

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

F. Place of Service

The specific procedure code billed determines the allowable place of service.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

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

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>