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**NC Division of Medical Assistance
Outpatient Behavioral Health Services
Provided by Direct-Enrolled Providers**

**Medicaid and Health Choice
Clinical Coverage Policy No. 8C
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:

1H, *Telemedicine and Telepsychiatry*

1A-38, *Special Services: After Hours*

1.0 Description of the Procedure, Product, or Service

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

These services are intended to determine a beneficiary's treatment needs, and to provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the beneficiary's functioning in familial, social, educational, or occupational life domains.

Outpatient behavioral health services are available to eligible beneficiaries and often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

Based on collaboration between the practitioner and beneficiary, and others as needed, the beneficiary's needs and preferences determine the treatment goals, frequency and duration of services, as well as measurable and desirable outcomes.

1.1 Definitions

1.1.1 Psychological Testing

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

1.1.2 Psychotherapy for Crisis

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

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

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

Medicaid

None Apply.

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 procedures, products, and services related to this policy when they are medically necessary, and:

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

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

3.2.1.1 Entrance Criteria

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

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

3.2.1.2 Continued Service Criteria

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

- a. Any ONE of the following criteria:

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

3.2.1.3 Discharge Criteria

Any ONE of the following criteria must be met:

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

3.2.1.4 Psychological Testing Criteria

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

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

3.2.1.5 Psychotherapy for Crisis Medical Necessity Criteria

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

The beneficiary must be experiencing at least ONE of the following, supported by session documentation:

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

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.2.4 Best Practice or Evidence-Based Practice

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

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

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

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

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover procedures, products, and services related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

4.2.1.1 Outpatient Behavioral Health

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

- a. sleep therapy for psychiatric disorders;
- b. when services are not provided face-to-face;

Note: Services provided according to the guidelines of clinical coverage policy 1H, *Telemedicine and Telepsychiatry* (located on DMA's website at <http://www.ncdhhs.gov/dma/mp/>), are considered as face-to-face services.

- c. when a beneficiary presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services;
- d. when the focus of treatment does not address the symptoms of the diagnosis;
- e. when the requirements and limitations in **Section 5.0** are not followed; and
- f. when Psychotherapy for Crisis codes are billed, the same provider shall not bill Special Services: After Hours codes (refer to clinical coverage policy 1A-38, *Special Services: After Hours*, located on DMA's website at <http://www.ncdhhs.gov/dma/mp/>) for the same event.

4.2.1.2 Psychological Testing

Medicaid and NCHC shall not cover Psychological Testing for the following:

- a. for the purpose of educational testing;
- b. if requested by the school or legal system, unless medical necessity exists for the psychological testing;
- c. if the proposed psychological testing measures have no standardized norms or documented validity;
- d. if the service is not provided face-to-face;
Note: Services provided according to the guidelines of clinical coverage policy 1H, *Telemedicine and Telepsychiatry* (located on DMA's website at <http://www.ncdhhs.gov/dma/mp/>), are considered as face-to-face services.
- e. if the focus of assessment is not the symptoms of the DSM-5 diagnosis; and
- f. when the requirements and limitations in **Section 5.0** are not followed.

4.2.1.3 Psychotherapy for Crisis

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

- a. if the focus of treatment does not address the symptoms of the DSM-5 diagnosis or related symptoms;
- b. for routine psychotherapy not meeting medical necessity criteria outlined in **Subsection 3.2.1**;
- c. in emergency departments, inpatient settings, or facility-based crisis settings. Refer to **Attachment A(F)** for place of service;
- d. if the beneficiary presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services; and
- e. when the requirements and limitations in **Section 5.0** are not followed.

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

Prior approval is not required for Psychotherapy for Crisis.
Refer to **Subsection 5.3** for limitations.

Medicaid and NCHC shall require prior approval for Psychotherapy for Crisis and Psychological Testing beyond the unmanaged visit limit. Refer to **Subsections 5.2 and 5.3** for limitations.

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

A beneficiary may have additional unmanaged visits per state fiscal year if he or she receives services under the Prepaid Inpatient Health Plan (also known in North Carolina as the LME-MCO). The PIHP may offer less restrictive limitations on unmanaged visits but may not offer more restrictive limitations than Medicaid policy. All visits beyond these limitations or limitations imposed by the Prepaid Inpatient Health Plan (PIHP) require prior approval. For Medicaid beneficiaries under the age of 21 and NCHC Beneficiaries there are no limits to the number of E/M codes allowed per year.

Prior authorization is not a guarantee of claim payment.

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

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 the following:

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

5.2.2 Specific

5.2.2.1 Medicaid Beneficiaries under the Age of 21

Outpatient behavioral health services coverage is limited to 16 unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes). A written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment). Services provided by any of the licensed professionals listed in **Subsection 6.1** below do not require a separate written service order. The licensed professional shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. The service order shall be signed prior to or on the first date of treatment (excluding the initial assessment).

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

5.2.2.2 Medicaid Beneficiaries Ages 21 and Over

Outpatient behavioral health services coverage is limited to eight (8) unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes). A written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment). Services provided by any of the licensed professionals listed in **Subsection 6.1** below do not require a separate written service order. The licensed professional shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. The service order shall be signed prior to or on the first date of treatment (excluding the initial assessment). To ensure timely prior authorization, requests must be submitted prior to the ninth visit.

5.2.2.3 NCHC Beneficiaries ages 6 through 18 years of age

Outpatient behavioral health services coverage is limited to 16 unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes). A written service order

by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment). Services provided by any of the licensed professionals listed in **Subsection 6.1** below do not require a separate written service order. The licensed professional shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. The service order shall be signed prior to or on the first date of treatment (excluding the initial assessment). To ensure timely prior authorization, requests must be submitted prior to the 17th visit. A new written order is required within 12 consecutive months of the initial visit and annually thereafter.

5.2.2.4 Medicare - Qualified Beneficiaries (MQB)

Medicaid prior authorization is not required for MQB.

Providers shall follow Medicare policies. For additional information on coordination of Medicare and Medicaid benefits, refer to **Attachment A**.

5.2.2.5 Authorization for multiple providers for the same service

If clinically appropriate, providers may submit the same authorization request for up to three (3) Medicaid Provider Numbers (MPNs) in one billing practice. All attending MPNs listed may be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary.

5.2.2.6 See Section 7.5 for psychological testing prior approval requirements.

5.3 Additional Limitations or Requirements

- a. Medicaid and NCHC shall not allow the same services provided by the same or different attending provider on the same day for the same beneficiary.
- b. Only one psychiatric CPT code from this policy is allowed per beneficiary per day of service from the same attending provider. This includes medication management services.
- c. Only two psychiatric CPT codes from this policy are allowed per beneficiary per date of service. These codes must be provided by two different attending providers.
- d. Family therapy must be billed once per date of service for the identified family member only. No separate billing for participating member(s) of the therapy session, other than the identified family member, is permissible.
- e. If Psychotherapy for Crisis is billed, no other outpatient services may be billed on that same day for that beneficiary.
- f. Only two add-on Crisis codes can be added to Psychotherapy for Crisis per event.
- g. A provider shall provide no more than two Psychotherapy for Crisis services per beneficiary, per state fiscal year.

- h. A Psychiatric Diagnostic Interview is not allowed on the same day as Psychological Testing when provided by the same provider. (See Section 7.5 for additional information on Psychological Testing)
- i. There is a limit of eight (8) units (hours) of Psychological Testing allowed per date of service.

5.4 Referral

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

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

In addition to physicians, the following providers may bill for these services. These licensed professionals are required to be currently licensed in North Carolina and to be direct enrolled in Medicaid (or PIHP) and bill under their own attending Medicaid Provider Numbers. These licensed providers cannot bill “incident to” a physician or any other licensed professional.

1. Licensed Psychologist (LP)
2. Licensed Psychological Associate (LPA)
3. Licensed Professional Counselor (LPC)
4. Licensed Professional Counselor Associate (LPCA)
5. Licensed Clinical Social Worker (LCSW)
6. Licensed Clinical Social Worker Associate (LCSWA)
7. Licensed Marriage and Family Therapist (LMFT)
8. Licensed Marriage and Family Therapist Associate
9. Licensed Clinical Addiction Specialist (LCAS)
10. Licensed Clinical Addiction Specialist – Associate (LCSA-A)

Note: The LME/MCO is not required to contract with providers credentialed by Medicaid, so providers should first check with the LME/MCO serving their prospective beneficiaries.

Note: Psychological Testing must only be performed by licensed psychologists, licensed psychological associates, and qualified physicians.

11. Certified Clinical Supervisor (CCS)

Note: DMA shall extend to Certified Clinical Supervisors who are not yet licensed, enrollment under a sunset clause that requires licensure by July 1, 2016.

12. Nurse Practitioners (NPs) certified as Psychiatric Mental Health Nurse Practitioner (PMHNP) and be approved to practice as a Psychiatric Mental Health Nurse Practitioner by a Joint Committee of the North Carolina Medical Board and the North Carolina Board of Nursing.

Note: DMA shall extend enrollment to NPs who are certified in another specialty with two years of documented mental health experience. These NPs shall be enrolled under a sunset clause that requires psychiatric certification by June 30, 2017 and, if this certification is not obtained by that date, the individual will no longer be able to provide behavioral health services under Clinical Coverage Policy 8C.

13. Certified Clinical Nurse Specialist (CNS) certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an adult or child/adolescent Psychiatric Mental Health Clinical Nurse Specialist – Board-Certified.

14. Licensed Physician Assistant (PA)

Note: The PA can directly enroll and bill for their services with the LME/MCO and, in the future, PAs will be required to be enrolled in order to provide services and prescriptions for Medicaid and North Carolina Health Choice beneficiaries. However, until further notice, the PA may also continue to bill “Incident To” a physician. “Incident To” requirements are found in the October 2008 Medicaid Bulletin at <http://www.ncdhhs.gov/dma/bulletin/1008bulletin.htm>

Note: Some of the providers listed above may not qualify as participating providers for Medicare or other insurance carriers.

The licensed professional shall be direct-enrolled with Medicaid and have their own Medicaid Provider Number (MPN) and National Provider Identifier (NPI). Only the individual licensed professional assigned to those numbers may use those numbers for authorization and billing of services. Allowing anyone else to use those numbers is considered fraud and individuals who do so are subject to administrative, civil, and criminal action and shall be reported to their occupational licensing board and Medicaid Program Integrity.

Professionals shall only provide treatment within the scope of practice, training, and expertise according to statutes, rules, and ethical standards of his or her professional occupational licensing board.

DMA Program Integrity or its designee shall recoup payment for services provided by unqualified professionals.

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, its divisions or its fiscal contractor(s).

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

7.2 Service Records and Documentation

7.2.1 Consent

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

7.2.2 Coordination of Care

The provider shall communicate and coordinate care with other professionals providing care to the beneficiary. The provider shall document coordination of care activities. The following are examples of coordination of care activities.

- a. Written progress or summary reports;
- b. Telephone communication;
- c. Treatment planning processes. An individualized plan of care, service plan, treatment plan, or Person-Centered Plan (PCP), consistent with and supportive of the service provided and within professional standards of practice, is required according to **Subsection 7.3.4** below. When the beneficiary is receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the beneficiary, and outpatient behavioral health services are to be incorporated into the beneficiary's PCP;
- d. Coordination of care with the beneficiary's CCNC/CA care manager (if applicable) and primary care or CCNC/CA physician;
- e. Coordination of care with PIHP (not applicable for NCHC beneficiaries); and

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

7.3 Clinical Documentation

7.3.1 Provision of Services

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

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

7.3.2 Outpatient Crisis Services

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

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

7.3.3 Comprehensive Clinical Assessment (CCA)

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

7.3.3.1 When a CCA is required

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

7.3.3.2 CCA Format

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

- a. description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
- b. chronological general health and behavioral health history (including both mental health and substance abuse) of the beneficiary's symptoms, treatment, and treatment response;
- c. current medications (for both physical and psychiatric treatment);
- d. a review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;
- e. evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
- f. analysis and interpretation of the assessment information with an appropriate case formulation;
- g. diagnoses from the DSM-5, including mental health, substance use disorders, or intellectual/developmental disabilities, as well as physical health conditions and functional impairment; and
- h. recommendations for additional assessments, services, support, or treatment based on the results of the CCA.
- i. The CCA must be signed and dated by the licensed professional completing the assessment.

7.3.3.3 A CCA is not required in the following situations:

- a. In primary or specialty medical care settings with integrated medical and behavioral health services, an abbreviated assessment is acceptable for the first six (6) outpatient therapy sessions. If additional therapy sessions are needed, then a CCA must be completed.

- b. Due to the nature of crisis services, a CCA is not required prior to Psychotherapy for Crisis services. However, the provider shall comply with the 10A NCAC 27G .0205(a) requirement for an assessment prior to the delivery of any subsequent services.
- c. For medical providers billing E/M codes for medication management.

Documentation in the health record must include the following:

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

7.3.4 Individualized Plan

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

The plan shall include at a minimum:

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

The plan must be developed based on the assessment and in partnership with the beneficiary or legally responsible person, the plan shall include each component listed in 10A NCAC 27G .0205(d).

For a child or adolescent receiving outpatient substance abuse services, the plan must document both the staff and the child or adolescent's signatures

demonstrating the involvement of all responsible parties in the development of the plan and the child or adolescent's consent or agreement to the plan. Consistent with N.C.G.S. § 90-21.5, the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan must require the signature of the parent or legally responsible person for the child or adolescent demonstrating the involvement of the parent or legally responsible person in the development of the plan and the parent's or legally responsible person's consent to the plan.

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

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

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

7.3.5 Service Notes and Progress Notes

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

- a. Date of service;
- b. Name of the service provided (e.g., Outpatient Therapy – Individual);
- c. Type of contact (face-to-face, phone call, collateral); non-face-to-face services are not covered and not reimbursable. Services provided in accordance with clinical coverage policy 1H, *Telemedicine and Telepsychiatry*, are considered as face-to-face services. Refer to <http://www.ncdhhs.gov/dma/mp/>
- d. Purpose of the contact (tied to the specific goals in the plan);
- e. Description of the treatment or interventions performed. Treatment and interventions must include active engagement of the beneficiary and relate to the goals and strategies outlined on the beneficiary's plan;
- f. Effectiveness of the intervention(s) and the beneficiary's response or progress toward goal(s);
- g. The duration of the service (e.g., length of the assessment or treatment in minutes);

- h. Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; and
- i. Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the beneficiary's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.

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

7.3.6 Referral and Service Access Documentation

a. Medicaid Beneficiaries under the Age of 21 and NCHC Beneficiaries ages 6-through 18 years

For Medicaid beneficiaries under the age of 21, and NCHC beneficiaries aged 6 years through 18 years of age, the following documentation must be kept in the health record:

- 1. The provider's signed treatment plan serves as the service order. A copy of the written order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level professional.
- 2. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from the DHHS Utilization Review Contractor is required.
- 3. All outpatient behavioral health services provided to a Medicaid beneficiary may be self-referred or referred by some other source. If the beneficiary is not self-referred, the referral must be documented in the health record

b. Medicaid Beneficiaries Aged 21 and Over

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

- 1. The provider's signed treatment plan serves as the service order. A copy of the written order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level professional.
- 2. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from the DHHS Utilization Review Contractor is required.
- 3. All outpatient behavioral health services provided to a Medicaid beneficiary may be self-referred or referred by some other source. If the beneficiary is not self-referred, the referral must be documented in the health record.

7.3.7 Electronic Signatures

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

7.4 24-Hour Coverage for Behavioral Health Crises

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

7.5 Psychological Testing

The following are additional requirements pertaining to Psychological Testing.

- a. Prior approval is required for all hourly Psychological Testing code requests of over eight hours even if the beneficiary has available unmanaged benefits. Prior approval assures medical necessity and authorizes the number of hours necessary to complete the psychological testing.

Note: the exception is that event-based psychological testing CPT codes do not require prior authorization if unmanaged visits are available.

- b. The appropriate allowed Psychological Testing CPT code(s) shall be utilized. The hours billed using the CPT code may include time spent performing the clinical interview, reasonable review of pertinent health records, performing the authorized Psychological Testing, scoring the Psychological Testing, interpreting the results of the Psychological Testing, and preparing a written report.
- c. Billing for psychological Testing must occur only on a date(s) when the beneficiary was seen face-to-face and can involve the activities described in item b above. However, the allowed psychological testing activities may have occurred on other dates when the beneficiary was not seen face-to-face. Each CPT code equals one unit even though a psychological testing CPT code may involve multiple hours of testing. Thus, five hours of psychological testing using a single testing code would count as one unit towards the beneficiary's managed or unmanaged visits.

7.6 Expected Clinical Outcomes

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

- a. Reduced symptomatology or abstinence, or decreased use of alcohol and other drugs;
- b. Employment or education (getting and keeping a job);
- c. Crime (decreased criminality);

- d. Stability in housing; and
- e. Increased social supports.

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

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

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 2005

Revision Information:

Date	Section Revised	Change
05/01/2005	Section 6.0	The requirements for nurse practitioners were revised to include a sunset clause that allows a five-year period for nurse practitioners who are certified in another specialty with two years of documented mental health experience a to obtain psychiatric certification.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
11/01/2005	Subsection 7.3.1	The requirement to list the beneficiary's name and Medicaid identification number on each page of the medical record was revised; providers are required to list the beneficiary's name and date of birth on each page of the medical record.
12/01/2005	Subsection 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Subsection 8.3	CPT code 96100 was end-dated and replace with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
09/01/2006	Section 6.0 and Subsection 8.3	Changed "certified" to "licensed" and abbreviations from CCS and CCAS to LCS and LCAS.
12/01/2006	Subsection 2.2	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
05/01/2007	Subsection 8.3	Services provided by licensed clinical addictions specialists and certified clinical supervisors were expanded to include psychiatric and psychotherapeutic procedure codes. CPT code 90809 was added to the certified nurse practitioner block.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
06/01/2007	Section 6.0, Subsection 8.3	Updated the title of Licensed Clinical Supervisor to Certified Clinical Supervisor; deleted CPT codes from list of codes a Certified Clinical Supervisor may bill.
06/01/2007	Sections 3 and 4	Added standard statements of coverage conditions.

Date	Section Revised	Change
06/01/2007	Subsection 5.3.3	Created separate category for MQB beneficiaries.
06/01/2007	Subsection 8.2	Added “substance abuse” to the first list item lettered “a.”
06/01/2007	Subsection 8.3, 2nd paragraph	Changed “mental health specific codes” to “behavioral health-specific codes.”
01/01/2011	Subsection 5.3.1.c	Number of visits changed from 26 to 16
01/01/2011	Subsection 7.3.2.b	26 changed to 16
01/01/2011	Subsection 7.3.2.c	27 changed to 17
01/01/2011	Section 8.0	Moved to Attachment A
01/01/2011	Section 9.0	Becomes Section 8.0
01/01/2011	Section 7.0	Added standard EPSDT statement
01/01/2011	Sections 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, 7.0	Updated with standard policy language
01/01/2012	Section 1.0	Behavioral health counseling deleted from description. Psychiatric medication management added.
01/01/2012	Subsection 5.1	Added “or different attending” and “for the same beneficiary” to item a. Updated language to b. Added items c, d, e, f, and g. e. Added administrative, civil and criminal action and shall be reported to occupational license board. f. Removed the example referring to scope of practice and provided clarification: provide treatment within the scope of practice, training, and expertise.
01/01/2012	Subsection 5.2	Changed Carolina Access to Community Care of North Carolina/Carolina Access (CCNC/CA). Added, “documentation of referral should be in the medical record. Added, must include name and NPI of referral source.
01/01/2012	Subsection 5.3	Changed 16 th visit to 17 th visit. A new written order is required within 12 months of initial visit and at least annually thereafter. Added piece on submitted prior approval requests prior to the 9 th visit for adults. Added Section on Authorization for multiple providers for the same service. Updated Place of Service section. Added note that prior approval for Medicaid 1915 (b)(c) waivers may vary from this policy. Revised section on prior approval. Added to 5.3.1, unmanaged visits inclusive of assessment and psychological testing codes. Revised Section 5.3.2.
01/01/2012	Subsection 5.4	Added clinic, nursing facility and other community settings to place of service. Revised Subsection 5.4.
01/01/2012	Subsection 5.5	Added section on Comprehensive Clinical Assessment (CCA). Clarified who may provide a CCA, incorporation of previous assessments in CCA, and documentation in service record.
01/01/2012	Subsection 5.6	Added Medical Necessity Criteria including Entrance, Continued Stay, and Discharge Criteria.

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

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

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

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

Date	Section Revised	Change
10/1/2015	All Sections and Attachments	Reviewed policy language for technical and grammatical errors and amended as needed to improve clarity.
10/1/2015	Subsection 3.2.1.1	Clarified entrance criteria pertaining to providing outpatient services when the beneficiary is assessed to need a higher level of care.
10/1/2015	Subsection 5.2.2	Allowed for fully licensed providers signature on their treatment plan to serve as an order for service as has been the case for psychologists and physicians. Also, clarified the requirements for documenting treatment plans.
10/1/2015	Subsection 5.4	Removed the requirement that children need a referral prior to services.
10/1/2015	Section 6.1	Extended the enrollment of nurse practitioners certified in another specialty to June 30, 2017 and gave notice that, in future, Physician Assistants will be required to directly enroll.
10/1/2015	Subsection 6.1	Included associate level providers as able to directly enroll.
10/1/2015	Subsection 6.2	This section was removed from the policy as Associate Level Professionals must be directly enrolled and the incident to billing has been discontinued.
10/1/2015	Subsection 7.2.2	Modified section on coordination of care to be less prescriptive.
10/1/2015	Subsection 7.3.3	Clarified that the CCA must be signed and dated by the licensed professional completing the assessment. Outlined the documentation requirements for the assessment that must be done if services are initiated prior to the full CCA being completed.
10/1/2015	Subsection 7.3.4	Clarified the requirements of the treatment plan bringing this section into compliance with administrative code. Also clarified that the plan shall be an identifiable document in the service record.
10/1/2015	Subsection 7.4	Clarified that 24 hour coverage for crises included the ability for the beneficiary to speak to a licensed clinician either face-to-face or telephonically.
10/1/2015	Subsection 7.5	Added this section outlining the requirements for psychological testing.

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)

B. International Classification of Diseases, Tenth Revision (ICD-10) Codes

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

Medicaid beneficiaries 21 and older and NCHC beneficiaries ages six to 18 years

The provider shall bill one diagnostic assessment (90791 or 90792) and up to five (5) units of one psychological testing assessment (96101, 96116, 96118) without a diagnosis of mental illness or a substance use disorder. These visits may be coded with an ICD-10 code corresponding to a DSM-5 "V" diagnosis code. All other visits require an ICD-10 code corresponding to a DSM-5 diagnosis code between 290 and 319.

Medicaid beneficiaries under the age of 21 and NCHC beneficiaries ages six to 18 years

The provider may bill up to six (6) visits without a diagnosis of mental illness or a substance use disorder. The following provisions related to diagnosis codes may be used:

- a. The first six (6) visits may be coded with an ICD-10 code corresponding to a DSM-5 "V" diagnosis code.
- b. A specific diagnosis code shall be used as soon as a diagnosis is established.
- c. Visits seven (7) and beyond require an ICD-10 code corresponding to a DSM-5 diagnosis code between 290 (Dementias) and 319 (unspecified intellectual disabilities).

Note: For a Medicaid beneficiary, these provisions related to diagnosis end on the last date of the birthday month in which a beneficiary turns 21 years of age. For a NCHC beneficiary age six to 18 years, these provisions for diagnosis end on the last date of the birthday month in which a beneficiary turns 19.

Providers shall diagnose to the highest level of specificity using DSM-5, however, claims are submitted using ICD-10 diagnosis codes. Providers shall utilize the appropriate ICD-10 diagnosis that corresponds to the chosen DSM-5 diagnosis. A DSM-5 to ICD-10 crosswalk is found in the DSM-5 manual.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-10 procedure codes, and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description as it is no longer documented in the policy.

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

It is each billing provider's responsibility to read, understand, and ensure compliance with published 2013 CPT guidance and DMA policy for services billed to Medicaid and PIHP s. There is no substitute for reading the 2013 CPT manual. There are limitations to use of code combinations and documentation requirements listed in the manual that are not listed in this policy, but which providers must adhere to when billing Medicaid and NCHC.

Physicians bill appropriate CPT codes which may include Evaluation and Management (E/M) codes. E/M codes are not specific to mental health and are not subject to prior approval. These codes are subject to the annual visit limit for adults. For Medicaid beneficiaries under the age of 21 and NCHC Beneficiaries ages 6 through 18 years there is no limit to E/M codes allowed per state fiscal year.

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

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

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

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

Code	Psychiatrist / MD	Psych NP	PA Incident to	LP/LPA	LPC/ LCSW/ LMFT/LCAS/ CCS/ CNS	Incident to by Associate Level	Prior Authorization (PA) / Unmanaged Visit Limits
90785	X	X	X	X	X	X	PA and visit limits do not apply; this code is an "add-on" to other codes (90791, 90792, 90832-90838, 90853) that do have PA and visit limits
90791	X	X	X	X	X	X	BH visit limits/PA requirements apply
90792	X	X	X				BH visit limits/PA requirements apply
90832	X	X	X	X	X	X	BH visit limits/PA requirements apply
90833	X	X	X				BH visit limits/PA requirements apply; code must be used with E/M code
90834	X	X	X	X	X	X	BH visit limits/ PA requirements apply
90836	X	X	X				BH visit limits/PA requirements apply; code must be used with E/M code
90837	X	X	X	X	X		BH visit limits/PA requirements apply
90838	X	X	X				BH visit limits/PA requirements apply; code must be used with E/M code
90839	X	X	X	X	X		Two per state fiscal year, no PA required
90840	X	X	X	X	X		No PA required; Must be used with 90839; two add-ons per 90839 event
90846	X	X	X	X	X	X	BH visit limits/PA requirements apply; may not be used with 90785
90847	X	X	X	X	X	X	BH visit limits/PA requirements apply; may not be used with 90785

90849	X	X	X	X	X		BH visit limits/PA requirements apply; may not be used with 90785
90853	X	X	X	X	X	X	BH visit limits/PA requirements apply
E/M Codes: 99201- 99255; 99304- 99337; 99341- 99350	X	X	X				E/M Visit limit is separate; DMA established adult limit is 22, does not count toward BH limits; Limit does not apply to diagnoses listed here: http://www.ncdhhs.gov/dma/provider/VisitLimitDiagnosesList.pdf or to beneficiaries under 21.
96101	X			X			PA requirements apply
96110	X	X	X	X			BH visit limits/PA requirements apply
96111	X			X			BH visit limits/PA requirements apply
96116	X			X			PA requirements apply
96118	X			X			PA requirements apply

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. As always, documentation in the record must clearly indicate who provided the service.

E. Billing Units

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

F. Place of Service

1. Medicaid Beneficiaries under the Age of 21

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

2. NCHC Beneficiaries ages 6 through 18 years

Office, clinics, schools, homeless shelters, home, and other community settings as clinically indicated.

3. Beneficiaries Aged 21 and Over

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

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

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

H. Reimbursement

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

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

I. Coordination of Care

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

Children with other insurance coverage are not eligible for NCHC coverage; therefore, there is no coordination of benefits under the NCHC Program.