

**Policy terminated because coverage is provided under equivalent Medicaid
Policy 8C, Outpatient Behavioral Health Services Provided by Direct-
Enrolled Providers**

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1.0 Description of the Procedure, Product, or Service

Outpatient psychotherapy is the treatment of psychiatric or chemical dependency disorders through scheduled therapeutic visits between the therapist and the recipient. Outpatient behavioral health psychotherapy services may be provided in an office, clinic or other locations appropriate to the provision of psychotherapy. The focus of outpatient psychotherapy treatment is to improve or maintain a recipient's ability to function as well as alleviate symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc). For children and adolescents, active family involvement and/or family therapy are expected unless contraindicated. The goals, frequency, and duration of outpatient treatment will vary according to recipient needs and response to treatment. A goal-oriented treatment focus, measurable outcomes, and a specific, realistic discharge plan must be developed as part of the initial assessment and outpatient treatment planning process; the discharge plan must be evaluated and revised as necessary as treatment progresses.

Episodic outpatient therapy is often sufficient for most recipients seeking outpatient treatment services, including those with more serious and persistent behavioral health conditions. Pharmacotherapy, plus ongoing, intermittent treatment by a licensed mental health professional (e.g. once or twice per month) may be necessary to maintain certain recipients' optimum functioning in order to ameliorate significant, often debilitating, symptoms and to prevent the need for more intensive treatment at higher levels of care.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

Note: Most children will be able to get all the services they need under the core (basic) plan of NC Health Choice. A child who qualifies as having special needs may be able to receive additional services not covered by the core plan.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers 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 recipient'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; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. The following providers and no others are covered for outpatient psychotherapy for both the initial 26 unmanaged visits and for the subsequent prior approved visits beyond 26:
 1. Licensed Psychiatrists

A psychiatrist licensed as an M.D. or D.O. in the state in which he or she performs any service covered by the NC Health Choice (NCHC) Program, who has completed a psychiatric residency approved by the American Council of Graduate Medical Education.
 2. Licensed Or Certified Doctors Of Psychology

A doctor of psychology who is licensed or certified in the state in which he or she performs any services covered under the Program. He or she will have a doctorate degree in psychology and has at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Provider in Psychology.
 3. Clinical Social Workers

A clinical social worker who is certified or licensed as a clinical social worker in the state in which he or she performs any service covered by the Program.
 4. Psychiatric Nurses
 - (a) A psychiatric nurse, licensed as a Registered Nurse in the state in which he or she performs any service covered by the Program, and who is certified as a clinical specialist in psychiatric mental-health nursing (Advanced Practice Registered Nurse A.P.R.N.).
 - (b) Any other psychiatric nurse, licensed as a Registered Nurse in the state in which he or she performs any services covered by the Program, and who is directly employed and supervised by an eligible doctor (as identified in **Subsection 3.2.a.1 and 2**). Direction and supervision must include the initial evaluation of the recipient by the eligible doctor and regular supervision conferences between the doctor and the employee. (Employment is interpreted to mean a normal salaried W-2 employer/employee relationship, not a per-case consultant contractual arrangement. The employment and supervision requirement is also met when employment is by an Area Mental Health Center and supervision is provided by an on-site eligible doctor.)
 5. Psychological Associates

An associate with a masters' degree in psychology, licensed as a psychological associate in the state in which he or she performs any services covered by the Program.
 6. Certified Fee-Based Practicing Pastoral Counselor

A Certified Fee-based Practicing Pastoral Counselor in the state in which he or she performs any service covered by the Program.

7. Licensed Professional Counselor

Licensed Professional Counselor in the state in which he or she performs any services covered under the Program.

8. Licensed Marriage And Family Therapist

A marriage and family therapist certified or licensed as a marriage and family therapist in the state in which he or she performs any service covered by the Program.

9. Licensed Physician Assistant

A Licensed Physician Assistant in the state in which he or she performs any service covered by the Program.

- b. Outpatient treatment of chemical dependency is covered under outpatient psychotherapy. All eligible providers listed in **Subsection 3.2.a** may provide outpatient chemical dependency services with appropriate substance abuse training and experience in the field of alcohol and other drug abuse, as determined by DMA's vendor, are authorized to provide treatment for chemical dependency in an outpatient setting. In addition, the following providers are also eligible to provide outpatient chemical dependency treatment only:

1. Licensed Physicians

A physician, licensed as an M.D. in the state in which he or she performs any service covered by the Program, and certified in substance abuse by the American Society of Addiction Medicine (ASAM).

2. Licensed Or Certified Clinical Addiction Specialist

A substance abuse counselor certified or licensed as an addiction specialist in the state in which he or she performs any service covered under the Program.

3. Licensed or Certified Clinical Supervisors

A substance abuse counselor certified or licensed as a certified substance abuse counselor and clinical supervisor in the state in which he or she performs any service covered under the Program.

4. Certified Substance Abuse Counselors

A substance abuse counselor certified or licensed as a certified substance abuse counselor in the state in which he or she performs any service covered under the Program.

5. Others as approved by DMA's vendor

In the absence of meeting one of the criteria above, DMA's vendor could consider, on a case-by-case basis, a provider who supplies:

- (a) Evidence of graduate education in the diagnosis and treatment of chemical dependency;
- (b) Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider);

AND

- (c) Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession
- c. Outpatient chemical dependency treatment must be consistent with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders
- d. All benefits for outpatient care are subject to the case management requirements for visits beyond the 26-visit threshold in each 12 month enrollment period.
- e. Medication management visits appropriately billed as 90862 do not require prior approval and are not counted toward the initial 26 visits allowed without case management. However, when 90862 is billed with a chemical dependency diagnosis, the visit will then count toward the 26 unmanaged visits.
- f. Up to 26 outpatient visits are covered in each 12 month enrollment period without getting prior approval. These visits are referred to as "unmanaged visits." The outpatient psychiatric and chemical dependency benefit is a combined benefit. All outpatient psychotherapy claims are applied to the single benefit of 26 unmanaged visits regardless of the diagnosis.
- g. The 26 unmanaged visits may also include payment within certain limits for early identification and treatment services. Such services are identified on the claim form as a deferred diagnostic code or a V-code, according to the following guidelines:
 - 1. No more than six (6) visits total may be billed and paid with a deferred diagnosis and/or V-code.
 - 2. A maximum of two (2) visits may be billed and paid with a deferred diagnosis code (799.90) and, the remainder of the six (6) visits must be billed and paid with a V-code.
 - 3. Providers of early intervention services must meet the same credentialing requirements as outlined in **Subsection 3.2.a** of this policy.
 - 4. Subsequent visits beyond the 6 visits must be billed with an Axis I diagnosis other than a V-code in order to be eligible for payment and meet prior approval requirements when beyond the 26 unmanaged visits.
- h. Behavioral health services for recipients who are deaf or hard of hearing may be authorized as in-network to signing or non-signing clinicians, as appropriate, based upon service recommendations from the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). Requests for such services may be made through DMA's vendor who will contact DMH/DD/SAS for specific referral options.
- i. A goal-oriented treatment focus, measurable outcomes, and a specific, realistic discharge plan must be developed as part of the initial assessment and outpatient treatment planning process; the discharge plan must be evaluated and revised as necessary as treatment progresses. Refer to **Section 1.0**.

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

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. Educational or achievement testing for the sole purposes of resolving educational performance questions is not covered.
- b. Psychological testing for conditions classified solely as a learning disability is not covered.
- c. Services provided by providers who do not meet the requirements as outlined in **Subsection 3.2** are not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is not required for the first 26 outpatient visits within each 12 month enrollment period.
- b. More than 26 visits in each 12 month enrollment period are covered only if approved in advance by DMA's vendor.
- c. The recipient's parent or guardian is responsible for keeping track of the number of outpatient mental health and chemical dependency visits received each 12 month enrollment period.
- d. The provider is responsible for submitting an Outpatient Request Form (ORF) to DMA's vendor prior to the 26th visit. In the event that the provider does not have an ORF, the recipient or provider may request the form be sent to the provider.
- e. The following services will count toward the 26 visit threshold and require approval if rendered after the 26th visit. These services should only be utilized as an adjunct to outpatient mental health treatment:
 1. Hypnotherapy
 2. Psychological testing

5.2 Code 90801

Psychiatric diagnostic interview code, 90801, is limited to one per provider per 12 month enrollment period. Each 90801 counts toward the 26 unmanaged visits; otherwise, prior approval by DMA's vendor is required.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **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.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

Refer to **Subsection 3.2g**.

C. Procedure Code(s)

CPT Codes
90801
90802
90804
90805
90806
90807
90808
90809
90810
90811
90812
90813
90814
90815
90849
90853
90857
90862
90846
90847

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Outpatient Hospital, Office

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.

Date of Termination 02.29.2012