

**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

Psychiatric home care services are psychiatric, psychological or psychotherapy services rendered by an eligible licensed mental health provider to a homebound recipient in his/her residence. Psychiatric home care is considered for benefits when the recipient can be safely treated in the place of residence in lieu of office-based or inpatient psychiatric treatment. A recipient is considered "homebound" if he/she has a medical condition as the primary reason for requiring home care services and has a psychiatric condition that also requires treatment.

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 initial clinical evaluation for psychiatric home care is not subject to prior approval by DMA's vendor, but will be retrospectively approved if psychiatric home care services are authorized.
- b. Benefits for covered psychiatric home care services are provided when:
 1. The attending physician refers the recipient for psychological or psychiatric in-home services.

2. An eligible mental health provider completes a comprehensive clinical assessment and treatment plan which outlines treatment in the home setting (clinical assessment and treatment plan requirements are noted in **Subsection 5.1**); and DMA's vendor (after reviewing all appropriate the documents in **3.2.b.1** and **3.2.b.2** above) concurs that psychiatric home care is a viable and appropriate alternative to a higher-or inpatient-level of care or an appropriate alternative to traditional office-based outpatient care, and that the mental health professionals providing care in the home setting have the appropriate licensure or certifications in accordance with State law.
3. Eligible mental health providers may provide psychiatric home care within the scope of their professional licensure and commensurate with their psychiatric experience, subject to prior approval by DMA's vendor.
- c. Supervision of approved psychiatric home care by the attending physician consists of the initial approval, ongoing review of the treatment plan, medical records, and medication regimen.
- d. Psychiatric home care services provided through a home care agency must meet all the treatment and provider requirements noted above, as well as be licensed or certified by the North Carolina Division of Health Service Regulation as a home care agency. Home Care agencies outside North Carolina must be appropriately licensed/certified by the licensing governmental agency in the state or country in which services are provided.

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

Psychiatric home care is not covered for the following:

- a. Psychiatric home care services that are not prior approved by DMA's vendor.
- b. Psychiatric home care services in excess of 60 days per 12 month enrollment period; additional days subject to review and approval by DMA's vendor.
- c. Psychiatric home care provided by ineligible providers.
- d. Care or treatment in the absence of a documented psychological or psychiatric illness or condition.

- e. Home care aide services.
- f. Chemical dependency as a primary diagnosis/reason for psychiatric home care.
- g. Psychiatric home care services for a recipient who is not homebound.
- h. Learning, educational, or tutoring either whole or in part.
- i. "Family Preservation Services," "intensive in-home services," in-home specialized intensive outpatient program services (IOP) or other similar services delivered in the home are not covered as psychiatric home care.
- j. Treatment or consultation provided by telephone.
- k. Psychiatric home care when a higher level of care is more appropriate or when traditional office-based outpatient treatment is more appropriate and possible.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for psychiatric home care.
- b. A treatment plan signed by the attending physician must be received by DMA's vendor prior to the initiation of psychiatric in-home services.
- c. A comprehensive clinical assessment and treatment plan will be reviewed by phone with DMA's vendor prior to the initiation of psychiatric in-home services. The following information must be included:
 - 1. presenting symptoms, level of function and date-of-onset;
 - 2. past psychiatric treatment;
 - 3. current medication(s);
 - 4. assessment of substance abuse or chemical dependency;
 - 5. social setting and level of family/caregiver support;
 - 6. current psychiatric condition (based on current DSM or ICD diagnosis codes);
 - 7. clinical justification for homebound status;
 - 8. treatment goals;
 - 9. description and frequency of proposed services;
 - 10. proposed end-date for homebound status; and
 - 11. credentials/certification of the treating mental health providers.
- d. DMA's vendor has the authority to withhold making a determination pending receipt of an appropriately signed treatment plan by the attending physician. DMA's vendor also reserves the right to request additional information, other than that which is noted above, in order to provide the recipient with a comprehensive review.

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.

C. Procedure Code(s)

CPT Code(s)				
90801	90802	90804	90805	90806
90807	90808	90809	90810	90811
90812	90813	90814	90846	90847
90849	90853			

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

Home

G. Co-payments

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

H. Reimbursement

Providers must bill their usual and customary charges.