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1.0 Description of the Procedure, Product, or Service

Health and Behavior Intervention provides intensive, focused counseling for pregnant and postpartum women who have serious psychosocial needs, which include individualized problem-solving, priority setting, instruction, and action planning to effect behavior modification or environmental change. It may include individualized treatment therapies designed specifically to aid in overcoming the identified problems. It may also include the involvement of the woman's significant other or other service providers.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

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

2.1.2 Specific

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

- a. Medicaid
None apply.
- b. NCHC
NCHC beneficiaries are not eligible for health and behavior intervention.

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..

2.3 Limitations

Pregnant and postpartum women who receive Medicaid and have one or more of the specified intensive psychosocial needs are eligible for this service.

Note: Postpartum is defined as the period of time from the last day of pregnancy through the last day of the month in which the 60th post-delivery day occurs.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Health and Behavior Intervention is covered for pregnant or postpartum women with one or more of the following conditions:

- a. Substance abuse (alcohol or drugs) or history of substance abuse with potential negative impact on the current pregnancy;
- b. Child abuse, family violence, or severe family dysfunction or history of such problems with potential negative impact on the current pregnancy;

- c. Severe emotional crises associated with situations such as loss of job, divorce, homelessness, death, terminal illness;
- d. Episodic disorders: severe depression, psychosis, behavior disorders;
- e. Suicidal tendencies;
- f. Intense negative feelings about the current pregnancy;
- g. Intense negative feelings about previous poor pregnancy outcome such as fetal death, stillborn, infant death, or congenital abnormalities;
- h. HIV infection/AIDS and other life-threatening medical problems;
- i. Pending incarceration during the pregnancy; or
- j. Major psychological behavioral disorders such as anorexia.

3.2.3 NCHC Additional Criteria Covered

None Apply.

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

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

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

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

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval for health and behavioral intervention.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

Health and Behavior Intervention services for pregnant and postpartum women should be face-to-face in the home or clinic (not the area mental health center). It can be provided by telephone when life-threatening situations exist.

Health and Behavior Intervention services may be provided in addition to services provided by the area mental health center. The two agencies may not provide the same service for the same reason or criteria. Counseling services must be coordinated to ensure continuity of care.

This short-term service may begin during the pregnancy and continue through the end of the month in which the 60th postpartum day occurs. Long-term counseling needs may necessitate referrals to other providers.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

- a. Local health departments are eligible to provide this service.
- b. This service must be rendered by a licensed clinical social worker.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

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

7.1 Compliance

- Provider(s) shall comply with the following in effect at the time the service is rendered:
- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
 - b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documentation Requirements

Initial and subsequent client contacts must be documented. The Intensive Psychosocial Counseling Initial and Subsequent Assessment forms, a narrative note, or Subjective data, Objective data, Assessment, and Plan of Action (SOAP) note are acceptable forms for documentation. If the narrative note is used, the reason for the referral, presenting problem, summary/impression, treatment plan, and disposition must be included.

Screening tools may be used in conjunction with the assessment tool. The tools are used to help identify and screen specific psychosocial problems such as: alcohol and/or substance abuse, depression, HIV infection/AIDS, domestic violence or suicidal tendencies.

Confidentiality of the records must be maintained.

Coordination of care strategies must be identified by all caregivers to avoid duplication of services.

At a minimum, the client's record must include the following documentation:

- a. Beneficiary's name and date of birth.
- b. Beneficiary's Medicaid identification number (MID).
- c. Dates of service.
- d. Documentation of initial and subsequent contacts.
- e. Plan of treatment/care and outcome.
- f. Total service time component (example: 35 minutes = 2 units).
- g. Name and title of person performing the service.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

| Date | Section Revised | Change |
|-------------|------------------------------|--|
| 9/1/05 | Section 2.0 | A special provision related to EPSDT was added. |
| 9/1/05 | Section 8.0 | Text stating that providers must comply with Medicaid guidelines was added to Section 8.0. |
| 12/1/05 | Section 2.3 | The web address for DMA's EDPST policy instructions was added to this section. |
| 12/1/06 | Sections 2 through 5 | A special provision related to EPSDT was added. |
| 5/1/07 | Sections 2 through 5 | EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age |
| 3/1/11 | Throughout | Updated policy with standard DMA template language and format |
| 3/1/11 | Attachment A | Updated billing guidelines to reflect transition from Maternity Care Coordination Program to Pregnancy Care Management Services |
| 3/3/11 | Attachment A | Revised to enhance integration with Pregnancy Medical Home/Pregnancy Care Management services |
| 3/12/12 | Throughout | Technical changes to merge Medicaid and NCHC current coverage into one policy. |
| 10/01/15 | All Sections and Attachments | Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable. |

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

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

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

| ICD-10-CM Code(s) | | |
|-------------------|---------|---------|
| O09.01 | O09.42 | O09.893 |
| O09.02 | O09.43 | O09.91 |
| O09.03 | O09.511 | O09.92 |
| O09.11 | O09.512 | O09.93 |
| O09.12 | O09.513 | Z33.1 |
| O09.13 | O09.521 | Z34.01 |
| O09.211 | O09.522 | Z34.02 |
| O09.212 | O09.523 | Z34.03 |
| O09.213 | O09.611 | Z34.81 |
| O09.291 | O09.612 | Z34.82 |
| O09.292 | O09.613 | Z34.83 |
| O09.293 | O09.621 | Z39.0 |
| O09.31 | O09.622 | Z39.2 |
| O09.32 | O09.623 | |
| O09.33 | O09.891 | |
| O09.41 | O09.892 | |

C. Code(s)

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

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

| CPT Code(s) |
|-------------|
| 96152 |

Unlisted Procedure or Service

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
One unit = 15 minutes.

F. Place of Service

Beneficiary's home, office.

G. Co-payments

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

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Providers shall bill their usual and customary charges.

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

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for beneficiaries enrolled in the Medicaid managed care programs.

Health and Behavior Intervention is reimbursed up to four units per day. One unit = 15 minutes, with a maximum of 44 units per pregnancy and postpartum. Claims for additional units will be considered for reimbursement through the adjustment process only when conditions of coverage are met and documentation supports medical necessity.

Health and Behavior Intervention must be billed per date of service.

Note: Pregnancy Care Management providers must follow all applicable guidelines pertaining to per member per month reimbursement model (PMPM).