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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 include psychiatric and biopsychosocial assessment, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible NC Medicaid *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*) and NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* 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 shall 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 or 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

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.
b. The beneficiary presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the (DSM-5), or any subsequent editions of this reference material, diagnosis.
c. The beneficiary does not require a higher level of care.
d. The beneficiary is capable of developing skills to manage symptoms, make behavioral changes, and respond favorably to therapeutic interventions.
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 include both "a." and "b." below:

a. Any 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,
    3. Tenuous nature of the functional gains;

b. Any 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.
   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 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.
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

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 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), or any subsequent editions of this reference material, diagnosis.
c. The beneficiary is capable of responding and engaging in psychological testing.
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 reimbursable 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.

3.3 Best Practice or Evidence-Based Practice

Outpatient behavioral health service providers, including those providing crisis services 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 or 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*, are considered as face-to-face services. Refer to http://www.ncdhhs.gov/dma/mp/);
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 (DSM-5), or any subsequent editions of this reference material, diagnosis;
e. when the requirements and limitations in **Section 5.0** are not followed; or

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*) 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* are considered as face-to-face services. Refer to http://www.ncdhhs.gov/dma/mp/);
e. if the focus of assessment is not the symptoms of the DSM-5 (or its successors) diagnosis; or
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), or any subsequent editions of this reference material, diagnosis or related symptoms;
b. for routine psychotherapy not meeting medical necessity criteria outlined in **Subsection 3.2.1**;
c. in settings other than outpatient. For example, it is not covered in emergency departments, inpatient settings, or facility-based crisis settings;
d. if the beneficiary presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services; or
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

In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover:

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."

Note: Subsection 4.2.3(b) applies to NCHC only.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for 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.

Prior approval is required for Psychotherapy and Psychological Testing beyond the unmanaged visit limit. Refer to **Subsections 5.2** and **5.3** for limitations. It is recommended that providers seek prior approval if they are unsure if the beneficiary has reached their unmanaged visit limit.

For Medical Evaluation and Management (E/M) services, adult beneficiaries are allowed 22 unmanaged visits (exclusions apply, refer to http://www.ncdhhs.gov/dma/provider/VisitLimitDiagnosesList.pdf) counted separately from psychotherapy and testing visit limits.

A beneficiary may have additional unmanaged visits per calendar year if he or she receives services under the Prepaid Inpatient Health Plan (also known as the LME-MCO). All visits beyond these limitations or limitations imposed by the Prepaid Inpatient Health Plan (PIPH) 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.

Note: When the provider is uncertain as to the number of visits that have been exhausted, it is recommended that the provider obtain prior approval.

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

Psychotherapy and Psychological Testing coverage is limited to 16 unmanaged outpatient visits per calendar year (inclusive of assessment and psychological testing codes). Visits beyond 16 per calendar year

require a written order by a physician, licensed psychologist (doctorate level), nurse practitioner (NP) or physician assistant (PA).

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 at least annually thereafter.

5.2.2.2 Medicaid Beneficiaries Ages 21 and Over

Psychotherapy and Psychological Testing coverage is limited to eight unmanaged outpatient visits per calendar year (inclusive of assessment and psychological testing codes). Visits beyond eight per calendar year require a written order by a physician, licensed psychologist (doctorate level), nurse practitioner (NP) or physician assistant(PA). To ensure timely prior authorization, requests must be submitted prior to the ninth visit. A new written order is required within 12 consecutive months of the initial visit and at least annually thereafter.

5.2.2.3 NCHC Beneficiaries ages 6 through 18 years of age

Psychotherapy and Psychological Testing coverage is limited to 16 unmanaged outpatient visits per calendar year (inclusive of assessment and psychological testing codes). Visits beyond 16 per calendar year require a written order by a physician, licensed psychologist (doctorate level), nurse practitioner(NP) or physician assistant(PA). 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 at least annually thereafter.

5.2.2.4 Medicare Qualified Beneficiaries (MQB)

Providers shall follow Medicare policies. Medicaid prior authorization is not required for beneficiaries in the MQB eligibility category. 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 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.

Note: Prior approval requirements for beneficiaries covered under PIPHs under the Medicaid 1915 (b)(c) waiver may receive additional unmanaged visits.

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 may be added to Psychotherapy for Crisis per event.
g. A provider shall provide no more than two Psychotherapy for Crisis services per beneficiary, per calendar year.
h. A Psychiatric Diagnostic Interview cannot be billed on the same day as psychological testing.
i. There is a limit of five units (hours) of psychological testing allowed per date of service.

5.4 Referral

5.4.1 Medicaid Beneficiaries under the Age of 21 and NCHC Beneficiaries ages six through 18 years

Outpatient therapy and psychological testing provided to Medicaid beneficiaries under the age of 21 and NCHC beneficiaries require an individual, verbal or written referral, based on the beneficiary's treatment needs by a Community Care of North Carolina/Carolina Access (CCNC/CA) primary care provider, the PIPH or a Medicaid-enrolled psychiatrist prior to or on the first date of service.

Documentation of this verbal or written referral must be in the health record and must include the name and NPI number of the individual or agency making the referral.

Psychotherapy for Crisis does not require a referral.

Note: Services provided by a physician do not require a referral.

5.4.2 Medicaid Beneficiaries Aged 21 and Over

All Outpatient Behavioral Health services provided to Medicaid beneficiaries age 21 or over may be self-referred or referred by some other source. If the beneficiary is not self-referred, documentation of the referral must be in 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 PIPH) 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 Clinical Social Worker (LCSW)
5. Licensed Marriage and Family Therapist (LMFT)
6. Licensed Clinical Addiction Specialist (LCAS)

   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.

7. Certified Clinical Supervisor (CCS)

   Note: DMA shall extend to certified clinical supervisors (CCS) who are not yet licensed, enrollment under a sunset clause that will require licensure by July 1, 2016.

8. Certified Psychiatric Nurse Practitioner (NP) approved to practice in North Carolina and certified by the American Nurses Credentialing Center as an advanced practice nurse practitioner and certified in psychiatric nursing

   Note: DMA shall extend enrollment to NP 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 at the end of a five-year period. If this certification is not obtained by June 30, 2015, enrollment must be terminated.

9. Certified Clinical Nurse Specialist (CNS) certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an advanced practice psychiatric clinical nurse specialist (CNS)

10. Licensed Physician Assistant (PA)

    Note: The PA and directly enroll and bill for their services with the LME/MCO. However, until further notice, the PA may also continue to bill “Incident To” a physician. Incident to requirements may be found in the October 2008 Medicaid Bulletin.

*Psychological testing must only be performed by licensed psychologists, licensed psychological associates, and qualified physicians.

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. (Refer to **Subsection 6.2.2** for 'incident to' billing under a physician for associate level licensed professionals ONLY.)

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 will recoup payment for services provided by unqualified professionals.

6.2 Non-Enrolled Licensed Professionals Eligible to Provide Services 'Incident To' a Physician

Associate Level Licensed Professionals
The following professionals registered with their individual respective licensing boards as associate level licensed professionals can provide reimbursable services that can be billed 'incident to' the services of a physician under the physician provider number:

a. associate level licensed clinical social workers;
b. associate level professional counselor associates;
c. licensed marriage and family therapist associates; and
d. associate level licensed clinical addiction specialists.

The associate level provider may continue to bill "incident-to" their supervising physician or bill through the LME/MCO until the associate level provider is able to direct enroll with DMA and the LME/MCO. At that time DMA will discontinue the associate level provider incident to policy.

Codes available for incident-to billing are outlined in Attachment A.

Note: Associate level licensed professionals are not permitted to bill 'incident to' any other provider except a physician.

6.2.1 Criteria for Billing 'Incident To' for Associate Level Licensed Professionals

In order for the associate level licensed professionals listed in **Subsection 6.2** above to provide services 'incident to' a physician, all of the following criteria must be met:

a. Employed by or have a contractual relationship with **one** of the following:
    1. Physician (individual or group);
    2. Behavioral health provider organization that employs a physician; or
    3. Behavioral health provider organization that contracts with a physician.

b. Practice at the same site where the physician practices.
    1. Services provided by the associate-level licensed professional are intended to be primarily office-based.
    2. If clinically indicated, the associate-level licensed professional may deliver the service in locations such as a beneficiary's home, school, office, or other community settings as long as the physician and the person providing clinical supervision both agree that the associate-level licensed professional has the skills to provide these services in locations outside the office and that the service location is clinically appropriate for the beneficiary.
    3. If the service location is outside the office, the physician shall document approval in the beneficiary's record, and the clinical supervisor shall document approval in the supervision record.
c. Provide only those services that have been determined to be medically necessary by the physician who is billing for the service and which meet the requirements in **Subsection 6.2.2.1 (a)**.
d. Adhere to all the rules of their respective boards relating to associate level licensure.
e. Provide only those services that are within the scope of practice for the applicable associate level licensure.

6.2.1.1 The physician billing 'Incident to'

The physician billing 'Incident to' shall adhere to **all** of the following criteria:

a. Have a face-to-face visit with the beneficiary, on or before the first visit during which the associate level licensed professional provides services, to determine or confirm medical necessity, if the physician does not already have an established relationship with the beneficiary. Documentation must be maintained by the physician to support medical necessity and the need for referral for outpatient therapy;
b. Be readily available to the associate level licensed professional at all times. (This means readily available by phone and able to return to the office if the beneficiary patient's condition requires it. The physician does not have to be on the same premises; however, the premises must be the location where the physician practices, except as noted in item **Subsection 6.2.2 b**);
c. Assume responsibility for the individual's work;
d. Add additional requirements at his or her discretion for the associate level licensed professional above and beyond those specified by the individual licensing boards;
e. Maintain documentation to support the verification process of all such licenses;
f. Verify and document who is providing the clinical supervision to the associate level licensed professional in the associate level licensed professional's personnel record, and ensure that the associate level licensed professional is receiving clinical supervision; and

g. Submit one authorization request per beneficiary for services provided by both the physician and the associate level licensed professional.

6.2.1.2 Supervision

a. The physician is primarily responsible for the services delivered by any individual and billed 'incident to' the physician's services.
b. Clinical supervision shall be provided according to the requirements of the respective licensing board of each associate level licensed professional.
    1. The associate-level licensed professional will need to arrange for a qualified clinical supervisor as determined by the respective board.
    2. The board-approved clinical supervisor assumes professional responsibility for the services provided by the associate level licensed professional and spends as much time as necessary directly supervising services to ensure that beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice.
    3. The supervisor does not have to be on site unless a qualified on-site supervisor is a board requirement. The supervisor shall be available by telephone while services are being provided.
c. Documentation as required by the licensing board must be kept to support the clinical supervision provided in the delivery of medically necessary services.

When services are provided to a **dually eligible Medicare/Medicaid beneficiary** the physician shall provide direct supervision. Direct supervision is defined as follows:

a. The physician has initially seen the beneficiary;
b. The physician shall be present in the office where the practitioner is providing the service and immediately accessible without delay in the event of an emergency; and
c. The physician shall be able to provide evidence of management of the beneficiary's care.

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 agent.

DMA Program Integrity or its contractor may recoup payment if any service provided was not rehabilitative in nature (i.e. habilitative or recreational activities, transportation, etc.). 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 coordinate and document the coordination of care activities, including the following:

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. 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 the physician who is providing 'incident to' oversight; and
f. Coordination of care with PIPH (not applicable for NCHC beneficiaries); and
g. Other activities jointly determined by the referring provider and the behavioral health provider to be necessary for the continuity of care.

Note: For coordination of care pertaining to billing, see 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, including 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 or 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 disposition must include offering a written copy of an individualized crisis plan. 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. Plan must include 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, intellectual/or developmental disability, and substance use disorder that results in the issuance of a written report, providing the clinical basis for the development of the beneficiary's treatment or service plan. The CCA written report must be included in the service record.

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, and 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.

7.3.3.1 When a CCA is required

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.

7.3.3.2 A CCA is not required in the following situations:

a. During the first six outpatient therapy services for brief treatment, provided in a primary or specialty medical care setting with integrated medical and behavioral health services. 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. It is expected that enrollees receiving this service shall either already have a CCA from prior treatment or shall have a CCA completed upon commencement of further services.
c. For medical providers billing E/M codes for medication management.

7.3.3.3 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 use) 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, 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, or any subsequent editions of this reference material, including mental health, substance use disorders, and/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.

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.

The plan must be developed based on the assessment and in partnership with the beneficiary or legally responsible person, the plan shall include:

a. Beneficiary outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;

b. Strategies and interventions;
c. A schedule for review of the plan at least annually, based on the date of the plan, in consultation with the beneficiary or legally responsible person or both;
d. Written consent or agreement of the plan by the beneficiary or legally responsible party, or a written statement by the provider stating why such consent could not be obtained; and
e. When a plan is developed with the beneficiary and his or her family, the plan must be signed and dated by the beneficiary, the parent or legally responsible person as required, and the person developing the plan.

For a child or adolescent receiving outpatient substance use disorder services, the plan must include 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.

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 includes 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, Telepsychiatry, phone call, collateral); non-face-to-face services are not covered and not reimbursable except for 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; and
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.

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, documentation must include:

1. A verbal or written individual referral based on the beneficiary's treatment needs from a CCNC/CA primary care provider, Medicaid-enrolled psychiatrist, or local management entity/PIPH (not applicable to NCHC beneficiaries) is required prior to or on the first date of service. Documentation of this verbal or written referral must be in the health record and must include the name and NPI number of the individual or agency making the referral;
2. A copy of the written order by the Physician, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 16th visit; and
3. For visits 17 and beyond, a copy of the completed authorization request form and prior approval notification from the DHHS Utilization Review Contractor is required.

Note: Services provided by a physician do not require a referral or order.

b. Medicaid Beneficiaries Aged 21 and Over

For Medicaid beneficiaries age 21 and over, documentation must include:

1. A copy of the written order by the physician, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 8th visit; and
2. For visits nine and beyond, a copy of the completed authorization request form and prior approval notification from the DHHS Utilization Review Contractor is required.

Note: Services provided by a physician do not require a referral or order.

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 shall 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 he or she is not available to respond to a beneficiary in crisis.

7.5 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 would include 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 include:

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.
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

Date	Section Revised	Change
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 16th visit to 17th 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 9th 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	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. 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.
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 7.3.4	Removed the Note at the end of the section that exempted providers only offering medication management from having the beneficiary or legally responsible person sign the treatment plan. This exemption contradicted Rule.
08/01/2014	Subsection 5.4.1	Added clarification that referrals are required prior to or on the first date of service.

Date	Section Revised	Change
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.

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, Ninth Revisions, Clinical Modification (ICD-9-CM) Codes

Provider(s) shall report the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-9-CM 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. **Before October 1, 2015**, the provider shall continue to use ICD-9 code sets to report medical diagnoses and procedural codes. **Effective October 1, 2015** the provider shall use ICD-10 code sets for reporting.

For Medicaid beneficiaries 21 and older and NCHC beneficiaries ages six to 18 years, Medicaid and NCHC cover one diagnostic assessment (90791 or 90792) and up to five units of one psychological testing assessment (96101, 96116, 96118) without a diagnosis of mental illness or a substance use disorder. This visit may be coded with a "V" diagnosis code. All other visits require an ICD-9-CM code between 290 and 319.

For Medicaid beneficiaries under the age of 21 and NCHC beneficiaries ages six to 18 years, Medicaid and NCHC cover up to six 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 two visits may be coded with ICD-9-CM code 799.9 (Other unknown and unspecified cause) and the following four visits can be coded with "V" diagnosis codes

   OR

   The first visit may be coded with diagnosis 799.9 and the remaining five can be coded with "V" diagnosis codes.

b. A specific diagnosis code shall be used as soon as a diagnosis is established.

c. Visits seven and beyond require an ICD-9-CM code between 290 (Dementias) and 319 (unspecified intellectual disabilities).

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

This policy covers services for the following diagnosis codes:

290	291	292	293	294	295	296	297	298	299
300	301	302	303	304	305	306	307	308	309
310	311	312	313	314	315	316	317	318	319
347	2900	2901	2902	2903	2904	2908	2909	2910	2911
2912	2913	2914	2915	2918	2919	2920	2921	2922	2928
2929	2930	2931	2938	2939	2940	2941	2948	2949	2950
2951	2952	2953	2954	2955	2956	2957	2958	2959	2960
2961	2962	2963	2964	2965	2966	2967	2968	2969	2970
2971	2972	2973	2978	2979	2980	2981	2982	2983	2984
2988	2989	2990	2991	2998	2999	3000	3001	3002	3003
3004	3005	3006	3007	3008	3009	3010	3011	3012	3013
3014	3015	3016	3017	3018	3019	3020	3021	3022	3023
3024	3025	3026	3027	3028	3029	3030	3039	3040	3041
3042	3043	3044	3045	3046	3047	3048	3049	3050	3051
3052	3053	3054	3055	3056	3057	3058	3059	3060	3061
3062	3063	3064	3065	3066	3067	3068	3069	3070	3071
3072	3073	3074	3075	3076	3077	3078	3079	3080	3081
3082	3083	3084	3089	3090	3091	3092	3093	3094	3098
3099	3100	3101	3102	3108	3109	3120	3121	3122	3123
3124	3128	3129	3130	3131	3132	3133	3138	3139	3140
3141	3142	3148	3149	3150	3151	3152	3153	3154	3155
3158	3159	3180	3181	3182	3321	3331	3337	7809	7876
7999	9955	29010	29011	29012	29013	29020	29021	29040	29041
29042	29043	29181	29182	29189	29211	29212	29281	29282	29283
29284	29285	29289	29381	29382	29383	29384	29389	29410	29411
29500	29501	29502	29503	29504	29505	29510	29511	29512	29513
29514	29515	29520	29521	29522	29523	29524	29525	29530	29531
29532	29533	29534	29535	29540	29541	29542	29543	29544	29545
29550	29551	29552	29553	29554	29555	29560	29561	29562	29563
29564	29565	29570	29571	29572	29573	29574	29575	29580	29581
29582	29583	29584	29585	29590	29591	29592	29593	29594	29595
29600	29601	29602	29603	29604	29605	29606	29610	29611	29612
29613	29614	29615	29616	29620	29621	29622	29623	29624	29625
29626	29630	29631	29632	29633	29634	29635	29636	29640	29641
29642	29643	29644	29645	29646	29650	29651	29652	29653	29654
29655	29655	29656	29660	29661	29662	29663	29664	29665	29666
29680	29681	29682	29689	29690	29699	29900	29901	29910	29911
29980	29981	29990	29991	30000	30001	30002	30009	30010	30011
30012	30013	30014	30015	30016	30019	30020	30021	30022	30023
30029	30081	30082	30089	30110	30111	30112	30113	30120	30121
30122	30150	30151	30159	30181	30182	30183	30184	30189	30250
30251	30251	30252	30253	30270	30271	30272	30273	30274	30275
30276	30279	30281	30282	30283	30284	30285	30289	30300	30301
30302	30302	30303	30390	30391	30392	30393	30400	30401	30402

30403	30410	30411	30412	30413	30420	30421	30422	30423	30430
30431	30432	30433	30440	30441	30442	30443	3450	30451	3452
30453	30460	30461	30462	30643	30470	30471	30472	30473	30480
30481	30481	30482	30483	30490	30491	30492	30493	30500	30501
30502	30503		30520	30521	30522	30523	30530	30531	30532
30533	30540	30541	30542	30543	30550	30551	30552	30553	30560
30561	30562	30563	30570	30571	30572	30573	30580	30581	30582
30583	30590	30591	30592	30593	30650	30651	30652	30653	30659
30720	30721	30722	30723	30740	30741	30742	30743	30744	30745
30746	30747	30748	30749	30750	30751	30752	30753	30754	30759
30780	30781	30789	30921	30922	30923	30924	30928	30929	30981
30982	30983	30989	31200	31201	31202	31203	31210	31211	31212
31213	31220	31221	31222	31223	31230	31231	31232	31233	31234
31235	31239	31281	31282	31289	31321	31322	31323	31381	31382
31383	31389	31400	31401	31500	31501	31502	31531	31532	31539
33382	33390		33392	33399	78009	78052	78054	78059	99550
99551	99552		99553	99554	99555	99581	99583	V11	V110
V111	V112		V113	V118	V119	V154	V1541	V1542	V1549
V1581	V40		V400	V401	V402	V403	V409	V6110	V6112
V612	V6120		V6121	V6129	V613	V614	V6141	V6149	V616
V617	V618	V619	V62	V620	V621	V622	V623	V624	V625
V626	V628	V6281	V6282	V6283	V6284	V6289	V629	V6252	V692
V693	V695	V7101	V7102	V7109	V79	V790	V791	V792	V793
V798	V799								

C. Code(s)

Provider(s) shall select 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-9-CM 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.

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 PIPH 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. However, 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 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 calendar 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			BH visit limits/PA requirements apply; limit of five hours per date of service
96110	X	X	X	X			BH visit limits/PA requirements apply
96111	X			X			BH visit limits/PA requirements apply
96116	X			X			BH visit limits/PA requirements apply; limit of five hours per date of service
96118	X			X			BH visit limits/PA requirements apply; limit of five hours per date of service

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.

When billing 'Incident to' for associate level licensed professionals, the modifier SC must be used after the CPT codes.

When billing the service code rendered by the associate level licensed professional, the NCCI modifier 59 shall be appended to CPT codes 90791, 90832, 90846, 90834, 99408, or 99409. The SC modifier shall also be used (as it is used currently) to indicate that the service was rendered by an associate level licensed professional billing 'incident to'. The use of these modifiers allows the system to recognize that the service was provided by a different attending provider. The other CPT codes (90832, 90834, 90847, and 90853) that associate level licensed professionals bill 'incident to,' cannot be overridden by appending modifiers, per federal guidelines. These codes can continue to be billed 'incident to' but need to be provided on a separate date of service to be considered for reimbursement. Alternatively, for individual therapy provided on the same date of service as medication management, the psychotherapy add-on code (90833 or 90836) can be billed to indicate that medication management and individual therapy were rendered. The SC modifier shall be used when billing the combined codes. 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 copayment 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. ICD-10-CM and Procedural Coding System(PCS) code(s), effective 10/01/2014

Provider(s) shall report the ICD-10 code set(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.

For services provided on or after October 1, 2015, the provider shall bill the applicable ICD-10-CM diagnosis code(s) and procedure code(s).

J. 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 1) the Medicare cost-sharing amount, or 2) 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.