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1.0 Description of the Procedure, Product, or Service

Outpatient behavioral health services include assessment, individual and group therapy, family therapy, psychiatric medication management, and psychological testing for recipients of all ages.

2.0 Eligible Recipients

All Medicaid-eligible recipients are eligible for services.

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. 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/or 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,

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product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.

b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide**:** http://www.ncdhhs.gov/dma/basicmed/

EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

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

a. the procedure, product or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure, product or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

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

3.2 Specific Criteria

Refer to **Section 5.0**.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate

a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

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

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

4.2 Specific Criteria

Services are not covered when the guidelines in **Section 5.0** are not followed.

Sleep therapy for psychiatric disorders is not covered.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

Services shall be individualized, specific, consistent with symptoms or with a confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.

5.1 Prior Approval

Children are allowed 16 unmanaged visits; adults are allowed 8 unmanaged visits per calendar year. All visits beyond these limitations require prior approval. Providers are responsible for obtaining prior approval from the Medicaid utilization review vendor. When the provider is uncertain as to the number of visits that have been exhausted, it is recommended that the provider obtain prior approval.

5.1.1 Recipients under the Age of 21

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 medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant, and prior approval from the utilization review contractor. To ensure timely prior authorization, requests should be submitted prior to the 17th visit. A new written order is required within 12 months of the initial visit and at least annually thereafter.

Recipients Aged 21 and Over
Coverage is limited to 8 unmanaged outpatient visits per calendar year (inclusive of assessment and psychological testing codes). Visits beyond 8 per calendar year require a written order by a medical doctor, licensed psychologist-(doctorate level), nurse practitioner or physician assistant, and prior approval from the utilization review contractor. To ensure timely prior authorization, requests must be submitted prior to the 9th visit. A new written order is required within 12 months of the initial visit and at least annually thereafter.

5.1.2 Medicare Qualified Beneficiaries

Providers must follow Medicare policies. Medicaid prior authorization is not required for recipients in the MQB eligibility category. For additional information on coordination of Medicare and Medicaid benefits, refer to Section 7.7.

5.1.3 Authorization for multiple providers for the same service

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

NOTE: Prior approval requirements for LMEs operating as Medicaid managed care vendors under the Medicaid 1915 (b)(c) waiver may vary from this policy.

5.2 Service Limitations

5.2.1 General Criteria

a. Medicaid does not reimburse for the same services provided by the same or different attending provider on the same day for the same recipient.

b. Only one psychiatric CPT code from this policy is allowed per recipient per day of service from the same attending provider. This includes 90862.

c. Only two psychiatric CPT codes from this policy are allowed per recipient 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. Licensed professionals 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 Section 6.1 for "incident to' billing under a physician for provisionally licensed professionals ONLY.]

f. 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.

5.3 Referral

5.3.1 Recipients under the Age of 21

Services provided to recipients under the age of 21 require a referral by a Community Care of North Carolina/Carolina Access (CCNC/CA) primary care provider, the local management entity or a Medicaid-enrolled psychiatrist.

Documentation of this referral must be in the medical record and must include the name and NPI number of the individual/agency making the referral.

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

5.3.2 Recipients Aged 21 and Over

Services provided to recipients age 21 or over may be self-referred or referred by some other source. If the recipient is not self-referred, documentation of the referral must be in the medical record.

5.4 Place of Service

5.4.1 Recipients under the Age of 21

Place of service is limited to the provider’s 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.

CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.

5.4.2 Recipients Aged 21 and Over

Place of service is limited to the provider’s 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.

CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.

5.5 Comprehensive Clinical Assessment (CCA)

A licensed or provisionally licensed professional shall complete a comprehensive clinical assessment that demonstrates medical necessity prior to provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning**,** and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and be included in the treatment/service plan.

A comprehensive clinical assessment is required when an individual presents for services and must be documented in the service record. The clinician may complete the CCA upon admission or update a recent CCA from another clinician. A comprehensive clinical assessment is an intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of the recipient's treatment/service plan, or when receiving enhanced behavioral health services (identified in Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services* - on DMA's Web site at http://www.ncdhhs.gov/dma/fee/), the recipient's Person Centered Plan (PCP),

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

a. chronological general health and behavioral health history (including both mental health and substance abuse) of the consumer's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
b. biological, psychological, familial, social, developmental and environmental dimensions and identifies strengths, weaknesses, risks, and protective factors in each area;
c. description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
d. strengths, protective factors, and problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;

e. strengths-based assessment that identifies the consumer and family functional strengths including natural and informal supports, preferences, needs, and cultural information specific to the family;

f. evidence of consumer and legally responsible person's (if applicable) participation in the assessment;

g. recommendation regarding target population eligibility (needed only for state-funded services);

h. analysis and interpretation of the assessment information with an appropriate case formulation; and

i. diagnoses on all five (5) axes of DSM-IV; and recommendations for additional assessments, services, support, or treatment based on the results of the comprehensive clinical assessment.

6.0 Providers Eligible to Bill for the Service

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

a. meet Medicaid's qualifications for participation;

b. be currently enrolled with N.C. Medicaid; 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

In addition to physicians, the following providers may bill for these services. These licensed professionals are required to direct enroll with Medicaid 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 psychologists (doctorate level)
2. licensed psychological associates (LPA)
3. licensed professional counselors (LPC)
4. licensed marriage and family therapists (LMFT)
5. licensed clinical social workers (LCSW)
6. nurse practitioners 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

or

Note: The Division of Medical Assistance (DMA) shall extend to nurse practitioners who are certified in another specialty with two years of documented mental health experience. These nurse practitioners will be enrolled under a sunset clause that will require psychiatric certification at the end of a five-year period. If this certification is not obtained by June 30, 2015, enrollment will be terminated.

7. clinical nurse specialists certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an advanced practice psychiatric clinical nurse specialist (CNS)
8. certified clinical supervisors (CCS)

   Note: The Division of Medical Assistance (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.
9. licensed clinical addictions specialists (LCAS)

Any provider who serves dually eligible recipients (i.e., Medicaid and Medicare or other insurance carriers) must be enrolled as a participating provider with each of the identified insurance carriers in order to be reimbursed. Note: Some of the providers listed above may not qualify as participating providers for Medicare or other insurance carriers.

6.2 Providers Eligible to Provide Services ‘Incident To’ a Physician’

6.2.1 Provisionally Licensed Professionals

The following professionals registered with their individual boards as provisionally licensed professionals can provide reimbursable services that can be billed ‘incident to’ the services of a physician under the physician provider number;

a. provisional licensed psychologists;
b. provisional licensed clinical social workers;
c. licensed professional counselor associates;
d. licensed marriage and family therapist associates; and
e. provisional licensed clinical addiction specialists.

Note: Provisionally licensed professionals are not permitted to bill ‘incident to’ any other provider except a physician.

6.2.2 Criteria for Billing ‘Incident To’

In order for the provisionally licensed professionals listed 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. a physician (individual or group);
   2. a behavioral health provider organization that employs a physician; or
   3. a behavioral health provider organization that contracts with a physician.
b. Practice at the same site where the physician practices.
   1. Services provided by the provisionally licensed professional are intended to be primarily office-based.
   2. If clinically indicated, the provisionally licensed professional may deliver the service in locations such as a recipient’s home, school, office, or other community settings as long as the physician and the

person providing clinical supervision both agree that the provisionally licensed professional has the skills to provide these services in locations outside the office and that the service location is clinically appropriate for the recipient.

3. If the service location is outside the office, the physician shall document approval in the recipient'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 6.1.3 (a)**.

d. Adhere to all the rules of their respective boards relating to provisional licensure.

e. Provide only those services that are within the scope of practice for the applicable provisional licensure.

6.2.3 The physician billing 'Incident to'

The physician billing "Incident to" shall:

a. Have a face-to-face visit with the recipient, on or before the first visit during which the provisionally licensed professional provides services, to determine or confirm medical necessity, if the physician does not already have an established relationship with the recipient. 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 provisionally licensed professional at all times. (This means readily available by phone and able to return to the office if the 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 6.2.3** ;

c. Assume responsibility for the individual's work;

d. Add additional requirements at his or her discretion for the provisionally 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 in the provisionally licensed professional's personnel record who is providing the clinical supervision to the provisionally licensed professional and ensure that the provisionally licensed professional is receiving clinical supervision;

g. Submit one authorization request per recipient for services provided by both the physician and the provisionally licensed professional.

6.2.4 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 provisionally licensed professional.
   1. The provisionally 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 provisionally licensed professional and spends as much time as necessary directly supervising services to ensure that recipients 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.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

7.1 Compliance

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

b. DMA Program Integrity or its designee may recoup payment if any service provided was not rehabilitative in nature (i.e. habilitative or recreational activities, transportation, etc.)

7.2 Service Records and Documentation

7.2.1 Consent

The provider is responsible for obtaining the written consent from the legally responsible person for treatment for recipients of all ages at the time of the initial service.

7.2.2 Coordination of Care

The provider is responsible for the coordination and documentation of 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 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 recipient is receiving multiple behavioral health services in addition to the services in this policy, a Person Centered Plan (PCP) must be developed with the recipient, and outpatient behavioral health services are to be incorporated into the recipient's Person Centered Plan;
d. Coordination of care with the recipient's case manager and primary care/CCNC physician;
e. Coordination of care with the physician who is providing 'incident to' oversight; and
f. Coordination of care with Local Management Entity / Managed Care Organization (LME/MCO); and
g. Other activities jointly determined by the referring provider and the behavioral health provider to be necessary for the continuity of care.

These coordination of care activities are included in the administrative costs for this service and are therefore not billable.

7.3 Clinical Documentation

7.3.1 Provision of Services

Providers must maintain records that document the provision of services for which Medicaid reimburses providers. Provider-organizations must maintain, in each recipient's service record, the following documentation (at a minimum):

a. Full sufficient demographic information, including the individual's full name, contact information, date of birth, race, gender, and admission date;
b. The recipient's name must be on each page generated by the provider agency;
c. The service record number of the individual must be on each page generated by the provider agency;
d. The Medicaid Identification Number for services reimbursed by Medicaid 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. A copy of any testing or summary and evaluation reports;
g. Documentation of communication regarding coordination of care activities; and
h. All evaluations, notes and reports must contain the full date the service was provided (month, day, and year).

7.3.2 Individualized Plan

An individualized plan of care, service plan, treatment plan, or Person Centered Plan, hearinafter referred to as "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 recipient is receiving multiple behavioral health services in addition to the services in this policy, a Person Centered Plan (PCP) must be developed with the recipient, and outpatient behavioral health services are to be incorporated into the recipient's Person Centered Plan.

The plan shall be developed based on the assessment and in partnership with the client or legally responsible person or both as outlined in 10A NCAC 27G .0205(d), the plan shall include:

a. Client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;
b. Strategies;
c. Staff responsible;
d. A schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;
e. Basis for evaluation or assessment of outcome achievement; and
f. Written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

When a plan is developed with the individual and his or her family, the plan shall be signed by the individual, the parent or legally responsible person as required, and the person developing the plan.

For minors receiving outpatient substance abuse services, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all 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 shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent to the plan.

7.3.3 Service Notes and Progress Notes

There must be a progress note for each treatment encounter and 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, phone call, collateral);
d. Purpose of the contact (tied to the specific goals in the plan);

e. Description of the treatment or interventions performed. Interventions Treatment and interventions must include active engagement of the individual and relate to the goals and strategies outlined on the individual's plan;
f. Effectiveness of the intervention(s) and the individual'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, or licensure of clinician who provided the service. Electronic signatures must adhere to DMA guidelines. A handwritten note requires a handwritten signature; however, the credentials, degree, or licensure may be typed, printed, or stamped.

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 individual's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.

7.4 Referral and Service Access Documentation

7.4.1 Recipients under the Age of 21

For recipients under the age of 21, documentation must include:

a. a referral from a Community Care of North Carolina/Carolina Access (CCNC/CA) primary care provider, Medicaid-enrolled psychiatrist or local management entity, (Documentation of this referral must be in the medical record and must include the name and NPI number of the individual/agency making the referral.) and
b. a copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 16th visit
c. a copy of the completed authorization form and prior approval notification from the utilization review contractor for visits 17 and beyond.

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

7.4.2 Recipients Aged 21 and Over

For recipients age 21 and over, documentation must include

a. a copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 8th visit
b. a copy of the completed authorization form and prior approval notification from the utilization review contractor for visits 9 and beyond.

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

7.5 24 Hour Coverage for Behavioral Health Crises

a. Enrolled providers shall provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services.

b. Enrolled providers shall arrange for coverage in the event that he or she is not available to respond to a recipient in crisis.

7.6 Expected Clinical Outcomes

The expected clinical outcomes must relate to the identified goals in the recipient's treatment plan. Outcomes can be classified in a variety of categories including health outcomes, recipient functioning outcomes, and recipient satisfaction outcomes. The outcomes must reflect changes in symptoms and behaviors that, when met, promote increased functioning such that recipient may no longer meet medical necessity criteria for further treatment. Continued stay criteria must include documentation of the need for ongoing treatment as well as progress made or efforts to address lack of progress.

Outcomes shall relate to one or more of the following National Outcome Measures developed by the Substance Abuse and Mental Health Services Administration as follows:

a. reduced morbidity (decreased mental illness 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. social connectedness.

For more information on the National Outcome Measures go to:
http://www.oas.samhsa.gov/NOMsCoOccur2k6.pdf

7.7 Coordination of Benefits

a. Any provider who serves dually eligible recipients (i.e., Medicaid and Medicare or other insurance carriers) must be enrolled as a participating provider with each of the identified insurance carriers in order to be reimbursed.

b. For recipients having both Medicaid and Medicare, the provider must bill Medicare as primary before submitting a claim to Medicaid. If both Medicare and Medicaid allow the service, Medicaid will pay the lesser of 1) the Medicare cost-sharing amount, or 2) the Medicaid maximum allowable for the service less the Medicare payment

c. For recipients having both Medicaid and any other insurance coverage, the other insurance must be billed prior to billing Medicaid, as Medicaid is considered the payor of last resort.

8.0 Policy Implementation/Revision Information

Effective Date: January 1, 2005

Revision Information:

Date	Section Revised	Change
5/1/05	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.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
11/1/05	Section 7.3.1	The requirement to list the recipient's name and Medicaid identification number on each page of the medical record was revised; providers are required to list the recipient's name and date of birth on each page of the medical record.
12/1/05	Section 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 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.
9/1/06	Sections 6.0 and 8.3	Changed "certified" to "licensed" and abbreviations from CCS and CCAS to LCS and LCAS.
12/1/06	Section 2.2	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
5/1/07	Section 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.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
6/1/07	Sections 6.0, 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.
6/1/07	Sections 3 and 4	Added standard statements of coverage conditions.
6/1/07	Section 5.3.3	Created separate category for MQB recipients.

Date	Section Revised	Change
6/1/07	Section 8.2	Added “substance abuse” to the first list item lettered “a.”
6/1/07	Section 8.3, 2nd paragraph	Changed “mental health specific codes” to “behavioral health–specific codes.”
1/1/11	Section 5.3.1.c	Number of visits changed from 26 to 16
1/1/11	Section 7.3.2.b	26 changed to 16
1/1/11	Section 7.3.2.c	27 changed to 17
1/1/11	Section 8.0	Moved to Attachment A
1/1/11	Section 9.0	Becomes Section 8.0
1/1/11	Section 7.0	Added standard EPSDT statement
1/1/11	Sections 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, 7.0	Updated with standard policy language
1/1/12	Section 1.0	Behavioral health counseling deleted from description. Psychiatric medication management added.
1/1/12	Section 5.1	Added “or different attending” and “for the same recipient” 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.
1/1/12	Section 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.
1/1/12	Section 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.
1/1/12	Section 5.4	Added clinic, nursing facility and other community settings to place of service. Revised Section 5.4.

Date	Section Revised	Change
1/1/12	Section 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.
1/1/12	Section 5.6	Added Medical Necessity Criteria including Entrance, Continued Stay, and Discharge Criteria.
1/1/12	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 provisionally licensed professional's personnel record. Deleted: When services are provided to a dually eligible Medicare and Medicaid recipient, the physician must provide direct supervision. Added 6.0(c) on enrollment when serving dually eligible recipients.
1/1/12	Section 7.1	Moved recoupment statement from Section 5 to Section 7.1.2
1/1/12	Section 7.2	To Section 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 recipient is receiving multiple behavioral health services in addition to the services in this policy, a Person Centered Plan (PCP) must be developed with the recipient, and outpatient behavioral health services are to be incorporated into the recipient's Person Centered Plan. Added coordination of care with LME/MCO and added coordination of care activities are not billable. Revised 7.2.1.

Date	Section Revised	Change
1/1/12	Section 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.
1/1/12	Section 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.
1/1/12	Section 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 recipients in crisis.
1/1/12	Section 7.7	Section on Coordination of Benefits added. Added Section a on dually eligible recipients and added Section c stating that Medicaid is payor of last resort.
1/1/12	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 provisionally licensed see the recipient on the same day.

Attachment A: Claims Related Information

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

A. Claim Type

Providers bill professional services directly to Medicaid's fiscal agent on the CMS-1500 claim form.

B. Diagnosis Codes That Support Medical Necessity

Providers must bill the ICD-9-CM (and its successors) diagnosis code to the highest level of specificity that supports medical necessity.

The following diagnosis codes should be used for services provided to recipients **under the age of 21:**

a. Medicaid covers six unmanaged visits without a diagnosis of mental illness or substance abuse.
b. The first two visits can 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

a. The first visit can be coded with diagnosis 799.9 and the remaining five can be coded with "V" diagnosis codes.
b. A specific diagnosis code should 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 mental retardation).

Note: This service coverage ends on the last date of the birthday month in which a recipient turns 21 years of age.

C. Procedure Codes

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 recipients under the age of 21 there is no limit to E/M codes allowed per year.

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 below.

Professional Specialty	**Related Codes**
Licensed Psychologist	96101, 96110, 96111, 96116, 96118, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849,90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Licensed Psychological Associate	96101, 96110, 96111, 96116, 96118, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Licensed Clinical Social Worker	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Licensed Professional Counselor	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Licensed Marriage and Family Counselor	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Certified Nurse Practitioner	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90862, 90805, 90807, 90809, 90811, 90813, 90815 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.

Professional Specialty	Related Codes
Certified Clinical Nurse Specialist	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Licensed Clinical Addictions Specialist	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Certified Clinical Supervisor	CPT Codes 90816, 90818, 90821, 90823, 90826, 90828 are only to be used for recipients in inpatient hospital or residential care facilities, defined as group homes, PRTFs, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, nursing facilities, and adult care homes.
Provisionally Licensed Professionals billing Incident To	The following CPT codes must be used (with the modifier SC): 90801, 90802, 90804, 90806, 90846, 90847, 90853, 99408, 99409

D. Modifiers

Providers are required to follow applicable modifier guidelines

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

When billing the service/code rendered by the provisionally licensed professional, the NCCI modifier 59 should be appended to CPT codes 90801, 90802, 90846, 99408, or 99409. The SC modifier should also be used (as it is used currently) to indicate that the service was rendered by a provisionally licensed professional billing 'incident to'. The use of these modifiers will allow the system to recognize that the service was provided by a different attending provider. The other CPT codes (90804, 90806, 90847, and 90853) that provisionally licensed professionals bill 'incident to,' cannot be overridden by appending modifiers, per federal guidelines. These codes can continue to be billed 'incident to' but will need to be provided on a separate date of service to be considered for reimbursement. Alternatively, for individual therapy codes 90804 and 90806, if medication management is provided on the same date of service, one code (90805 or 90807) can be billed to indicate that medication management and individual therapy were rendered. The SC modifier should be used when billing the combined codes. As always, documentation in the record should clearly indicate who provided the service.

E. Billing Units

1 CPT code = 1 unit of service.

F. Place of Service

Refer to **Subsection 5.4**

G. Co-payments

Co-payments are not deducted for services provided to recipients less than 21 years of age. Providers shall follow co-payment rules outlined in the *Basic Medicaid Billing Guide* http://www.ncdhhs.gov/dma/basicmed/

H. Reimbursement Rate

Providers shall bill their usual and customary charges.

Payment is made according to the specialty of the attending provider billing for the service, whether practicing independently or employed by group practices. Fee schedules can be found at http://www.ncdhhs.gov/dma/fee/.