

**Psychological Services Provided by  
Health Departments to the  
Under 21 Population**

**Original Effective Date: July 1, 2002  
Revised Date: May 1, 2007**

**Psychological Services Provided by  
School-Based Health Centers Sponsored  
by Health Departments to the  
Under 21 Population**

**Original Effective Date: November 1, 2000  
Revised Date: May 1, 2007**

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## **1.0 Description of the Service**

Psychological services for children and adolescents through age 20 are goal-directed interventions designed to enable children, adolescents, and their families to cope more effectively with complex problems. Services may include comprehensive psychosocial assessments and treatment planning, goal-directed psychotherapy (individual, group, and/or family), and/or referral to other mental health resources as needed.

These services involve the identification of and intervention with children and adolescents who may be **at risk** for developing more serious emotional/behavioral problems as well as those who are already experiencing these problems. Early identification and intervention helps prevent inappropriate and costly referrals. Making these services available in health departments and in school-based health centers contributes to client choice and enhances the coordination of physical and behavioral health services.

Goals of this service include the following:

- a. preventing the development of serious emotional/behavioral problems in children and adolescents
- b. Increasing effective coping and problem-solving skills of children, adolescents, and their parents
- c. Facilitating effective communication between children and parents
- d. Increasing parental understanding of child and adolescent development and behavior
- e. Strengthening the child's and/or family's support system to more effectively meet their needs

## **2.0 Eligible Recipients**

### **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 Limitations**

Medicaid-eligible children under the age of 21 receiving services through a health department or a school-based health center sponsored by a health department are eligible for these services.

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

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, 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/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

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### 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, see **Section 2.0** of this policy.

All services must be medically necessary. One of the following ICD-9-CM diagnosis codes must be present to substantiate medical necessity:

295.0 through 304.9  
305.0  
305.2 through 305.9  
307.9  
307.50  
307.51  
307.54  
308.0 through 309.9  
311 through 314.9  
799.9  
V11.0 through V11.9  
V15.41 and V15.42  
V40.0 through V40.9  
V61.0  
V61.11  
V61.20  
V61.21  
V61.41  
V61.7  
V61.9  
V62.2  
V62.3  
V62.4  
V62.81, V62.82, and V62.83  
V62.9  
V65.42  
V65.44  
V70.1 and V70.2

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#### 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, see **Section 2.0** of this policy.

Services are not covered when the medical criteria listed in **Section 3.0** are not met.

#### 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, see **Section 2.0** of this policy.

Assessment must always include the child or adolescent and in many cases should also include the parent or caregiver. Psychotherapy is focused on the needs of the child/adolescent but may include sessions with only the parents/caregivers when such sessions are in the interest of the child/adolescent. Individualized treatment plans must be designed to build upon strengths and overcome identified problems.

After a comprehensive psychosocial assessment using an age-appropriate tool or format, one of the following actions should occur:

- a. The client's need for mental health intervention cannot be met by the health department or school-based health center mental health provider and an appropriate referral is made to another provider.
- b. A treatment plan based on the client's strengths and needs and involving the client/family is developed and implemented for those clients to be followed through the public health system.
- c. If the assessment indicates no need for further psychosocial intervention services, this information is provided to the referral source as appropriate.

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Up to 6 early intervention visits and a total of 26 unmanaged visits are allowed per calendar year before prior approval must be obtained. The CPT codes are subject to prior approval before the 27th visit in any calendar year. A request for additional sessions beyond 26 should be submitted by the 18th visit to allow time for processing.

**Note:** The 26 visits include any outpatient mental health services by any provider during the calendar year.

Up to two early intervention visits may be billed as Deferred Diagnosis (799.9). The remainder of the six early intervention visits may be billed using a V code. After these six early intervention visits, a non-V-code primary diagnosis must be established.

If a client is seen by a mental health provider in a health department or school-based health center and is referred and seen for emergency mental health services on the same day, both providers may be reimbursed.

A client may receive psychological services in the health department or school-based health center sponsored by a health department in conjunction with mental health services provided by another agency, as long as services are coordinated and non-duplicative.

Outpatient behavioral health services must be provided in accordance with the requirements and procedures documented in **Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers***, including the requirement to obtain a referral from the Carolina ACCESS primary care provider, the local management entity, or a Medicaid-enrolled psychiatrist for services provided to recipients under the age of 21.

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

## 6.0 Providers Eligible to Bill for the Service

Psychological services must be provided by one of the following:

- a. Licensed Clinical Social Workers (LCSW)
- b. Advanced Practice Psychiatric Clinical Nurse Specialists (CNS)
- c. Advanced Practice Psychiatric Nurse Practitioners (NP)
- d. Licensed Psychologists

All providers must function within the scope of practice of their state license and certification.

Medical or other remedial care or services provided by licensed health care practitioners employed by Medicaid providers enrolled as health departments and school-based health clinics (sponsored by health departments) must be provided by or rendered under the overall direction and supervision of:

- a. a physician licensed under state law to practice medicine or osteopathy, or
- b. other individuals approved to perform medical acts, tasks, or functions (nurse practitioners, certified nurse midwives, physician assistants).

<b>Division of Medical Assistance</b>	<b>Clinical Coverage Policy No.: 8I</b>
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The supervising practitioner may be employed by or under contract with the health department or school-based health clinic. Supervision does not mean that the practitioner is required to be present when the service is rendered, but must be "immediately available" via telephone or pager.

## **7.0 Additional Requirements**

The following must be documented in the client's medical record:

- a. Reason for referral (or reason for visit).
- b. Assessment results from a standard assessment protocol.
- c. Diagnosis.
- d. A treatment plan signed by clinician and client (parent/guardian for a younger child).
- e. Each intervention, including the date and duration of the session in minutes.
- f. Notes must be related to the treatment plan and must describe the purpose of the contact, the nature of the intervention, and the effectiveness/outcome of the intervention (client's response to the intervention).
- g. Signature and credentials of the person providing the service.

The following should also be documented, as appropriate:

- a. Consults with other professionals.
- b. Follow-up plan.
- c. Release of information signed by client (parent/guardian for a younger child).

## **8.0 Billing Guidelines**

### **8.1 Claim Type**

CMS-1500 (through HSIS)

### **8.2 Diagnosis Codes that Support Medical Necessity:**

Refer to Section 3.0.

### **8.3 Procedure Codes**

Effective July 1, 2002, for health departments and effective November 1, 2000, for school-based health centers sponsored by health departments, the following CPT codes may be billed for psychological services for the under-21 population: 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90853.

The following services can be provided in a clinic, office, home, or school: 90801, 90802, 90846, 90847, 90853.

By CPT code definition, the following services can be provided only in a clinic or office setting: 90804, 90806, 90808, 90810, 90812, 90814.

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The 90846 code must be billed if parents/caregivers are seen for therapy without the client present.

**Note:** Please refer to the most recent edition of the American Medical Association's Current Procedural Terminology for code definitions.

#### **8.4 Reimbursement Rate**

Providers must bill their usual and customary charges.

### **9.0 Policy Implementation/Revision Information**

**Original Effective Dates:**

**Health Departments:** July 1, 2002

**School-Based Health Centers Sponsored by Health Departments:** November 1, 2000

**Revision Information:**

<b>Date</b>	<b>Section Updated</b>	<b>Change</b>
12/1/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/1/03	Section 8.0	Subsection numbers were added to the subsection titles.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The Web address for DMA's EDPST policy instructions was added to this section.
8/1/06	Section 5.0	Information on referral requirements and a reference to Clinical Coverage Policy 8C was added to the end of the section.
12/1/06	Section 2.3	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	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.