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Related Service Definition Clinical Policies

Refer to https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/service-definitions for the related state-funded service definition clinical policies listed below:

State-Funded Telehealth and Virtual Communications Services
State-Funded Enhanced Mental Health and Substance Abuse Services
State-Funded Assertive Community Treatment (ACT) Program

1.0 Description of the Service

Outpatient behavioral health services are psychiatric and comprehensive clinical assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for individuals who meet DMH/DD/SAS Benefit Plan criteria.

Outpatient services for Substance Use Disorders (SUD) are for individuals assessed as meeting, at minimum, American Society of Addiction Medicine (ASAM) level of 0.5 Early Intervention or 1.0 (Outpatient Services). Services include psychiatric and comprehensive clinical assessments, medication management, individual, group and family therapies, psychotherapy for crisis, psychological testing, and Screening, Brief Intervention, Referral, and Treatment (SBIRT).

These services determine an individual's treatment needs and provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms to improve functioning in familial, social, educational, or occupational life domains. Outpatient behavioral health services often involve the participation of family members, natural supports, and legally responsible person(s) as applicable, unless contraindicated.

The individual's needs and preferences are based on collaboration between the practitioner and the individual to determine treatment goals, frequency and duration of services and measurable and desirable outcomes.

1.1 Definitions

a. Psychological Testing
Psychological testing involves the culturally and linguistically appropriate administration of standardized tests to assess an individual's psychological or cognitive functioning. Testing results must inform treatment selection and treatment planning.

b. Psychotherapy for Crisis
On rare occasions, licensed outpatient service providers are presented with an individual in crisis 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 situations in which an unforeseen crisis 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 is a short-term emergency behavioral health intervention restricted to outpatient crisis assessment, stabilization, and disposition for acute, life-threatening situations.

c. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
SBIRT is an ASAM level 0.5 early intervention approach for an individual with non-dependent substance use to effectively help them before more extensive or specialized treatment is needed. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for individuals with substance use disorders, as well as those who are at risk of developing these disorders. Provider shall use a standardized screening tool, such as the Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST-10), or Screening to Brief Intervention (S2BI) tool.

Universal screening helps identify the appropriate level of services needed based on the risk level and determine if the individual would benefit from brief intervention or referral to treatment services.

SBIRT services can be provided in a variety of settings by professionals included in **Section 6.0**, to systematically screen and assist individuals who may not seek assistance for substance use problems. SBIRT services can:

1. reduce health care costs;
2. decrease the severity of drug and alcohol use;
3. reduce the risk of physical trauma; and
4. reduce the percent of individuals who go without specialized treatment.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

a. An eligible individual shall be enrolled with the LME-MCO on or prior to the date of service, meet the criteria for a state-funded Benefit Plan and shall meet the criteria in Section 3.0 of this policy.

b. Provider(s) shall verify each individual’s eligibility each time a service is rendered in order to bill state funds.

2.1.2 Specific

None Apply.

3.0 When the Service Is Covered

3.1 General Criteria Covered

State funds shall cover services related to this policy when they are medically necessary, and:

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

3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy can be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in State-Funded Telehealth and *Virtual Communications Services,* at https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/service-definitions.

3.1.2 Telephonic Services

As outlined in **Attachment A**, select services within this clinical coverage policy can be provided via the telephonic, audio-only communication method. Telephonic services must be transmitted between an individual receiving services and provider in a manner that is consistent with the CPT code definition for those services.

This service delivery method is reserved for circumstances when:

a. physical or behavioral health status prevent the individual from participating in-person or telehealth services; or
b. access issues (transportation, telehealth technology) prevent the individual from participating in-person or telehealth services.

Refer to **Subsection 3.2.2** for Telephonic-Specific Criteria; **Subsections 5.1 and 5.2** for Prior Approval requirements; and **Subsection 7.1** for Compliance requirements.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

State funds shall cover outpatient behavioral health services when the individual meets the following criteria:

3.2.1.1 Entrance Criteria

All of the following criteria are necessary for admission of an individual to outpatient treatment services:

a. A current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [(DSM-5) or any subsequent editions of this reference material] diagnosis;
b. The individual presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the current diagnosis;
c. If a higher level of care is indicated but unavailable or the individual is refusing the service, outpatient services can be provided until the appropriate level of care is available or to support the individual to participate in that higher level of care;
d. The individual 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 (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Board of Addiction Medicine); and

3.2.1.2 Continued Service Criteria

The criteria for continued service must meet both "a." and "b." below:

a. Any ONE 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 individual's treatment plan;
   2. The individual continues to be at risk for relapse based on current clinical assessment, and history: or
   3. Tenuous nature of the functional gains.
b. Any ONE of the following criteria (in addition to "a.")
   1. The individual has achieved current treatment plan goals, and additional goals are indicated as evidenced by documented symptoms; or
   2. The individual 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 ONE of the following criteria must be met:

a. The individual's level of functioning has improved with respect to the goals outlined in the treatment plan;
b. The individual or legally responsible person no longer wishes to receive these services; or
c. The individual, 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 (National Institute of Drug Abuse, American Psychiatric Association).

3.2.1.4 Psychological Testing Criteria

ALL of the following criteria are necessary entrance criteria for psychological testing services:

a. A current 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 individual presents with behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with the current DSM-5, or any subsequent editions of this reference material, diagnosis;
c. The individual is capable of responding and engaging in psychological testing; and.
d. There is no evidence to support that alternative tests would be more effective, based on North Carolina community practice standards (American Psychological Association).

3.2.1.5 Psychotherapy for Crisis Medical Necessity Criteria

Psychotherapy for Crisis is only covered when the individual is experiencing an immediate, potentially life-threatening, complex crisis situation. The service must be provided in an outpatient therapy setting.

The individual shall experience 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 Telephonic-Specific Criteria

State funds shall cover telephonic services when the following criteria are met:

a. Providers shall obtain prior authorization in advance of delivering services via telephone only;
b. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
c. Providers shall consider an individual’s behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
d. The individual’s safety shall be carefully considered for the complexity of the services provided;
e. In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, their ability to assist and their safety is also considered;

f. Delivery of services using telephonic, audio-only communication must conform to professional standards of care consisting of ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and Licensing Board rules;
g. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented;
h. Providers shall verify the individual's identity using two points of identification before initiating a telephonic, audio-only encounter; and
i. Providers shall ensure that the individual's privacy and confidentiality is protected.

3.2.3 Additional Criteria Covered

None Apply.

3.2.4 Best Practice or Evidence-Based Practice

Outpatient behavioral health service providers and those providing Psychotherapy for Crisis and psychological testing, shall be trained in and follow a rehabilitative best practice or evidence-based treatment model consistent with NC 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 individual 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 Service Is Not Covered

4.1 General Criteria Not Covered

State funds shall not cover services related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by State Funds

4.2.1.1 Outpatient Behavioral Health

State funds shall not cover Outpatient Behavioral Health Services for the following:

a. sleep therapy for psychiatric disorders;
b. when services are not provided in-person or in accordance with Attachment A;

c. when an individual 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 diagnosis;

e. when the requirements and limitations in **Section 5.0** are not followed; and

4.2.1.2 Psychological Testing

State funds 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 in-person or according to **Attachment A;**

e. if the focus of assessment is not the symptoms of the current diagnosis; and

f. when the requirements and limitations in **Section 5.0** are not followed.

4.2.1.3 Psychotherapy for Crisis

State funds shall not cover Psychotherapy for Crisis under the following circumstances:

a. if the focus of treatment does not address the symptoms of the current diagnosis or related symptoms;

b. when services are not provided in-person or according to **Attachment A;**

c. for routine psychotherapy not meeting medical necessity criteria outlined in **Subsection 3.2.1**;

d. in emergency departments, inpatient settings, or facility-based crisis settings. Refer to **Attachment A(F)** for place of service;

e. if the individual presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services; and

f. when the requirements and limitations in **Section 5.0** are not followed.

4.2.2 Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State funds shall not require prior approval for Outpatient Behavioral Health services. Refer to **Subsections 5.3.1.1 through 5.3.1.6** for limitations.

Prior authorization is not a guarantee of claim payment.

Note: Providers can seek prior approval if they are unsure the individual has reached their unmanaged visit limit.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the LME-MCO or utilization management vendor (UM vendor) the following:

a. the prior approval request; and
b. all service records and any other records that support the individual has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

State funds shall require prior approval for services provided via the telephonic, audio-only communication method.

5.3 Utilization Management and Additional Limitations

5.3.1 Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an individual who meets a state-funded Benefit Plan.

Services are based upon a finding of medical necessity, must be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the individual's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the LME-MCO or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly effective as services requested by the individual's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an authorization after the unmanaged units have been used, the Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA), service order for medical necessity, the treatment plan or Person-Centered Plan

(PCP), and the required state-funded authorization request form must be submitted to the LME-MCO or utilization management contractor prior to the unmanaged units ending. Refer to **Subsection 7.3.3.1**

5.3.1.1 Individuals under the Age of 18

Outpatient Behavioral Health Services have 16 unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes).

To ensure timely authorization, requests must be submitted prior to the 17th visit.

5.3.1.2 Individuals Ages 18 and Over

Outpatient Behavioral Health Services have a minimum of eight unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes).

To ensure timely prior authorization, requests must be submitted prior to the ninth visit.

5.3.1.3 Psychological testing prior approval requirements

Refer to **Subsection 7.5** for psychological testing prior approval requirements.

5.3.2 Additional Limitations

a. State funds shall not allow the same services provided by the same or different attending provider on the same day for the same individual.

b. A written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment).

c. Services provided by the licensed professionals listed in **Subsection 6.1** below, other than the Associate Level Professionals, do not require a separate written service order. These licensed professionals shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. The service order shall be signed prior to or on the first day of treatment (excluding the initial assessment.)

d. If an urgent or emergent situation presents the need for a verbal service order, basic procedures must be followed for the verbal service order to be valid. Treatment may proceed based on a verbal service order by the appropriate professional as long as the verbal service order is documented in an individual's service record on the date that the verbal service order is given. The documentation must specify the date of the service order, who gave the service order, who received the service order, and identify each distinct service that was ordered. The documentation should reflect why a verbal service order was obtained in lieu of a written service order. The appropriate professional must countersign the service order with a dated

signature within seventy-two (72) hours of the date of the verbal service order.

e. Only one psychiatric CPT code from this policy is allowed per individual per day of service from the same attending provider.
f. Only two psychiatric CPT codes from this policy are allowed per individual per date of service. These codes must be provided by two different attending providers.
g. 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.
h. If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that individual.
i. A Psychiatric Diagnostic Interview is not allowed on the same day as Psychological Testing when provided by the same provider. (See **Subsection 7.5** for additional information on Psychological Testing)
j. There is a limit of eight hours of Psychological Testing allowed to be billed per date of service.
k. For substance use disorders, ASAM level 1 outpatient services are provided for less than nine hours a week for adults and less than six (6) hours a week for adolescents.
l. Outpatient Medication Management and Outpatient Psychiatric Services cannot be billed while an individual is authorized to receive Assertive Community Treatment.
m. Individual, Group, or Family Outpatient services cannot be billed while an individual is authorized to receive:
    1. Assertive Community Treatment (ACT);
    2. Intensive In-Home (IIH);
    3. Multisystemic Therapy (MST);
    4. Day Treatment;
    5. Substance Abuse Intensive Outpatient (SAIOP); or
    6. Substance Abuse Comprehensive Outpatient Treatment (SACOT).

5.4 Referral

If an individual is not self-referred, the referral must be documented in the service record.

6.0 Providers Eligible to Bill for the Service

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

a. meet a state-funded Benefit Plan for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement, and
c. bill only for 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 can bill for these services:

a. Licensed Psychologist (LP);

b. Licensed Psychological Associate (LPA);

c. Licensed Professional Counselor (LPC) or Licensed Clinical Mental Health Counselor (LCMHC);

d. Licensed Professional Counselor Associate (LPCA) or Licensed Clinical Mental Health Counselor Associate (LCMHCA);

e. Licensed Clinical Social Worker (LCSW);

f. Licensed Clinical Social Worker Associate (LCSWA);

g. Licensed Marriage and Family Therapist (LMFT);

h. Licensed Marriage and Family Therapist Associate (LMFTA);

i. Licensed Clinical Addiction Specialist (LCAS);

j. Licensed Clinical Addiction Specialist Associate (LCASA);

k. Licensed Physician Assistant (PA);

l. Nurse Practitioner (NP), including Psychiatric Mental Health Nurse Practitioner (PMHNP);

m. Licensed Physician Assistants and Nurse Practitioners can be eligible to provide substance use disorder treatment prescriber services in an Opioid Treatment Program setting to an individual diagnosed with a substance use disorder if they meet the Federal opioid treatment standards under 42 CFR 8.12 and have an approved exemption from the Substance Abuse Mental Health Services Administration (SAMHSA.) These PAs and NPs must be supervised by a psychiatrist or other physician with experience practicing addiction medicine;

n. Certified Clinical Nurse Specialist (CNS) certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an adult or child/adolescent Psychiatric Mental Health Clinical Nurse Specialist – Board-Certified.

o. The licensed professional shall be direct-enrolled with the LME/MCO and have their own National Provider Identifier (NPI). Only the individual licensed professional assigned to those numbers can use those numbers for authorization and billing of services. These licensed providers cannot bill "incident to" a physician or any other licensed professional.

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, and, as relevant, according to the scope outlined in a clinical supervision agreement.

All PAs and NPs providing psychiatric services must practice under the supervision of a psychiatrist.

Note: Per 25 USC 1621t "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

7.0 Additional Requirements

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), 42 CFR Part 2 and record retention requirements; and
b. All Division of MH/DD/SAS's service definition clinical policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by DHHS, its divisions or its fiscal contractor(s). Federally recognized tribal and Indian Health Service (IHS) providers may be exempt to one or more of these items in accordance with Federal, Tribal laws and rules.

DHHS or a designated contractor may recoup payment if any service provided was not rehabilitative in nature such as habilitative or recreational activities or transportation. 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 individuals of all ages.

7.2.2 Coordination of Care

The provider shall communicate and coordinate care with other professionals providing care to the individual. The provider shall document coordination of care activities. Coordination of care activities can include:

a. Written progress or summary reports;
b. Telephone calls;
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 according to **Subsection 7.3.4** below. When the individual is receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the individual, and outpatient behavioral health services are to be incorporated into the individual's PCP;

d. Coordination of care with the individual's comprehensive case manager, primary care, or other NC DHHS recognized integrated care providers; and
e. Coordination of care with the LME-MCO.

Note: For coordination of care pertaining to billing, refer to **Attachment A**.

7.3 Clinical Documentation

7.3.1 Provision of Services

Providers shall maintain service records that document the provision of services for which state funds can be reimbursed to providers. Provider-organizations shall maintain, in each individual's service record, at a minimum, the following documentation:

a. Demographic information: the individual's full name, contact information, date of birth, race, gender, and admission date;
b. The individual'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 service record number for services reimbursed by state funds must be on all treatment plans, service note pages, accounting of release, 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, 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 (behavioral health urgent care center, facility-based crisis, emergency department, inpatient hospitalization) if documentation supports this decision.
b. If the disposition is not an immediate transfer to acute or more intensive emergency services, the provider shall offer a written copy of an individualized crisis plan to the individual. This plan must be developed in the session for the purpose of handling future crisis situations, including involvement of family and other providers as applicable. The plan must document a scheduled outpatient follow-up session.

7.3.3 Comprehensive Clinical Assessment (CCA)

A CCA is an intensive clinical and functional evaluation of an individual's presenting mental health, developmental disability, and substance use disorder. This assessment results in the issuance of a written report that provides the clinical basis for the development of the individual's treatment or service plan. The CCA written report must be kept in the service record.

a. A licensed clinician shall complete a CCA that contains an ASAM level of care determination on an individual diagnosed with a substance use disorder; and shall have documentation verifying the completion of training on the current 2013 ASAM Criteria edition, or any subsequent editions of this reference material, consisting at minimum of the following learning objectives:
   1. Review paradigm shifts and evolutions in generations of care that led to The ASAM Criteria;
   2. Apply The ASAM Criteria's decisional flow;
   3. Identify and describe the six ASAM criteria assessment dimensions;
   4. Rate risk and severity across all dimensions;
   5. Identify services and modalities needed, as well as treatment planning approaches;
   6. Identify appropriate levels of care;
   7. Review special populations and emerging research about addiction; and
   8. Develop strategies to overcome real-world barriers to implementing The ASAM Criteria.

Training must be a minimum of ten (10) hours to ensure the above identified learning objectives are addressed. It is expected that clinicians using the ASAM for CCAs completed for individuals with a SUD seek out continuing education opportunities to maintain current knowledge of the ASAM criteria. Federally recognized tribal and IHS providers may complete an alternate curriculum to satisfy the identified learning objectives.

7.3.3.1 When a CCA is required

According to 10A NCAC 27G .0205(a), 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. 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. 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.

7.3.3.2 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 contain **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, past trauma history and behavioral health history (consisting of mental health and substance use, and tobacco use) of the individual's symptoms, treatment, and treatment response;
c. current medications for medical, psychiatric, and substance use disorder treatment. Identify past medications that were ineffective or caused significant side effects or adverse reactions;
d. a review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;
e. evidence of the individual and legally responsible person's (if applicable) participation in the assessment;
f. analysis and interpretation of the assessment information with an appropriate case formulation, consisting of a determination of ASAM level of care when a substance use disorder is present;
g. diagnoses using current the DSM-5, or any subsequent editions of this reference material, consisting of mental health, substance use disorders, or intellectual and developmental disabilities, as well as physical health conditions and functional impairment;
h. recommendations for additional assessments, services, support, or treatment based on the results of the CCA; and
i. The CCA must be signed and dated by the licensed professional completing the assessment.

7.3.3.3 A CCA is not required in the following situations:

a. In primary or specialty medical care settings with integrated medical and behavioral health services, an abbreviated assessment is acceptable for the first six outpatient therapy sessions. 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. However, the provider shall comply with the 10A NCAC 27G .0205(a) requirement for an assessment prior to the delivery of any subsequent services.
c. For medical providers billing E/M codes for medication management.

7.3.3.4 Documentation in the service record must include the following:

a. the individual's presenting problem;
b. the individual's needs and strengths;
c. a provisional or admitting diagnosis, with an established diagnosis within 30 calendar days;
d. a pertinent social, family, and medical history; and
e. other evaluations or assessments as appropriate.

7.3.4 Individualized Plan

An individualized plan of care, service plan, treatment plan, or PCP, 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 contact with an individual. This plan is based on the assessment and is developed in partnership with the individual or legally responsible person, or both. When services are provided prior to the establishment and implementation of the plan, strategies to address the individual's presenting problem must be documented. The plan must be an identifiable document in the service record.

The plan must contain at a minimum:

a. the outcomes 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 (in consultation with the individual or legally responsible person or both) as needed but at least annually to review goals and strategies to promote effective treatment;
e. basis for evaluation or assessment of outcome achievement; and
f. written consent or agreement by the individual or legally responsible person, or a written statement by the provider stating why such consent could not be obtained.

For a child or adolescent receiving outpatient substance use services, the plan must document 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 or comparable federal, Tribal law, or rule, 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.

The treatment plan must be updated as required, but a new plan is required at least annually.

All treatment plans must be developed in partnership with the individual or legally responsible person, and all updated or new plans require the individual or legally responsible person's signature, and the licensed professional's signature. The licensed professional's signature on the updated or new plan can serve as the service order.

Note: Individuals receiving medication management only would be exempt from the requirement of having to sign the treatment plan. For individuals 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 individuals 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 documents the following information:

a. Date of service;

b. Name of the service provided;

c. Type of contact (in-person, telehealth, telephonic, or collateral); Services eligible to be provided via telehealth must be provided according to State-Funded Telehealth and Virtual Communications Services policy, at https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/service-definitions;

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 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, length of the assessment or treatment in minutes;

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

Note: 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. Individuals under the Age of 18

For individuals under the age of 18, the following documentation must be kept in the service record:

1. The provider's signed treatment plan which serves as the service order.
2. A copy of the written service order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level professional.

3. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from the LME/MCO or UM contractor is required.
4. If the individual is not self-referred, the referral must be documented in the service record.

b. Individuals Aged 18 and Over

For individuals age 18 and over, the following documentation must be kept in the service record:

1. The provider's signed treatment plan serves as the service order.

   A copy of the written order by the physician, licensed psychologist, nurse practitioner, or physician assistant for the services of the associate level professional.
2. For visits beyond the unmanaged visits, a copy of the completed authorization request form and prior approval notification from the LME/MCO or UM contractor is required.

   If the individual is not self-referred, the referral must be documented in the service record.

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 Division of MH/DD/SAS Records Management and Documentation Manual must 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 they are not available to respond to an individual in crisis. This coverage must incorporate the ability for the individual to speak with the licensed clinician on call either in-person, via telehealth, or telephonically.

7.5 Psychological Testing

The following are additional requirements pertaining to Psychological Testing services.

a. Unmanaged coverage is limited to eight (8) hours of service per state fiscal year for Psychological Testing services. Prior approval is required for services that will exceed the unmanaged limit. Prior approval assures medical necessity and authorizes the number of hours necessary to complete the psychological testing.

b. The appropriate allowed Psychological Testing CPT code(s) shall be used.

c. Billing for performing the Psychological Testing must occur only on a date(s) when the individual is seen in-person. However, allowed Psychological Testing activities may occur on other dates when the individual is not seen in-person and be billed using the appropriate Psychological Testing CPT code(s).

d. A service note must be written for each Psychological Testing service(s) contact that includes:

   1. Name of the individual receiving this service;
   2. Service record number of the individual;
   3. Service Record Number (for services reimbursed by state funds);

4. Date(s) of service documenting month, day, and year;
5. Name of the service provided and CPT codes(s);
6. Purpose of the psychological testing;
7. Name(s) of the individual tests administered;
8. Total amount of time to be billed on this date of service for psychological testing; and
9. Signature and date signed of the psychologist, LPA, or physician with degree and licensure.

Note: Only one service note is required to be written for a Psychological Testing code(s) and an add-on code(s) if services are provided on the same day and by the same provider.

This information serves to document the psychological testing service. The timeline for service notes documenting psychological testing is the same as other service notes and must be written or dictated within 24 hours of the day that the service was provided. After 24 hours the note is considered a late entry. If the note is not written or dictated within seven days of the day that the service was provided, the service may not be billed. After 24 hours, the note must be indicated as a late entry and must have a dated signature.

In addition to a service note for each encounter with the individual, a written report of the psychological testing must be completed and sent to the individual or organization making the referral in a time frame according to the individual's needs and clinical best practice standards. At a minimum this report must contain the following:

a. Reason for the referral;
b. Psychological tests/procedures utilized;
c. Review of records as appropriate;
d. Results of the psychological tests;
e. Interpretation of the psychological tests;
f. Summary;
g. Diagnosis or Diagnostic Impression;
h. Recommendations; and
i. Signature, date signed, degree, and license of the psychologist, LPA, or physician.

Often psychological testing reports contain the information found in a Comprehensive Clinical Assessment (CCA).

7.6 Expected Clinical Outcomes

The expected clinical outcomes must relate to the identified goals in the individual's treatment plan. The outcomes must reflect changes in symptoms and behaviors that, when met, promote increased functioning such that the individual no longer meets medical necessity criteria for further treatment. Expected clinical outcomes for this service are the following:

a. Reduced symptomatology or abstinence, or decreased use of substances;
b. Vocational or educational gains;
c. Decreased engagement with the justice system;

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 provide the following:

a. documentation of the need for ongoing treatment; and
b. documentation of progress made; or documentation of efforts to address lack of progress.

8.0 Policy Implementation/Revision Information

Original Effective Date: June 1, 2023

Revision Information:

Date	Section Revised	Change
6/1/23		State-funded service definition policy implementation.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Joint Communication bulletins, fee schedules, NC Division of MH/DD/SAS service definition clinical policies and any other relevant documents for specific coverage and reimbursement for state funds.

Note: Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

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

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

Individuals under the age of 18 and older

The provider can bill 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 six visits can be coded with an ICD-10 code corresponding to a DSM-5 “V” diagnosis code.

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

c. Visits seven and beyond require an ICD-10 code corresponding to a DSM-5 diagnosis code between 290 (Dementias) and 319 (unspecified intellectual disabilities).

Note: These provisions related to diagnosis end on the last date of the birthday month in which an individual turns 18 years of age.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and ICD-10 procedure codes and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description as it is no longer documented in the policy.

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

It is each billing provider's responsibility to read, understand, and ensure compliance with published CPT guidance and Division of MH/DD/SAS policy for services billed to state funds. There is no substitute for reading the 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 state funds.

Physicians bill appropriate CPT codes which can contain Evaluation and Management (E/M) codes.

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 must 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.

SBIRT services must only be billed when a clinician provides screening and brief intervention. If a brief intervention is not clinically indicated, time spent providing the screening must be incorporated in the time for other services rendered.

Psychiatric Diagnostic Evaluation, Psychotherapy, Medication Management, Crisis, and Psychological Testing CPT Codes

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, and CNS	Unmanaged Visit Limits	Telehealth Eligible	Telephonic Eligible
+90785	X	X	X	X	X	This code is an "add-on" to other codes (90791, 90792, 90832-90838, 90853) that do have PA and visit limits	X	X
90791	X	X		X	X	BH visit limits apply	X	
90792	X	X	X			BH visit limits-apply	X	
90832	X	X		X	X	BH visit limits apply	X	X
+90833	X	X				BH visit limits apply; code must be used with E/M code	X	
90834	X	X		X	X	BH visit limits apply	X	X
+90836	X	X				BH visit limits; code must be used with E/M code	X	
90837	X	X		X	X	BH visit limits apply	X	X
+90838	X	X				BH visit limits; code must be used with E/M code	X	
90839	X	X		X	X	No PA required	X	X
+90840	X	X		X	X	Must be used with 90839;	X	X
90846	X	X		X	X	BH visit limits; may not be used with 90785	X	X

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, and CNS	Unmanaged Visit Limits	Telehealth Eligible	Telephonic Eligible
90847	X	X		X	X	BH visit limits; may not be used with 90785	X	X
90849	X	X		X	X	BH visit limits; may not be used with 90785	X	X
90853	X	X		X	X	BH visit limits apply	X	X
E/M Codes: 99202**-99255; 99304-99337; 99341-99350; 99417**	X	X	X			BH visit limits apply	X Telehealth eligible codes are limited to the following: • 99202-99205 • 99211-99215 • 99231-99233 • 99238-99239 • 99241-99245 • 99251-99255 • 99347-99350	
99408	X	X	X	X	X	No PA required	X	
99409	X	X	X	X	X	No PA required	X	
96110	X	X		X		BH visit limits apply	X	

Code	Psychiatrist / MD/DO	PMHNP	PA/NP	LP/ LPA	LCMHC, LCMHCA, LPC, LPCA, LCSW, LCSWA, LMFT, LMFTA, LCAS, LCASA, CCS, and CNS	Unmanaged Visit Limits	Telehealth Eligible	Telephonic Eligible
96112	X			X		BH visit limits apply		
96113	X			X		BH visit limits apply; Must be used with 96112		
96116	X			X		No PA required	X	
96121	X			X		BH visit limits apply; Must be used with 96116	X	
96130	X			X		BH visit limits apply	X	
96131	X			X		BH visit limits apply; Must be used with 96130	X	
96132	X			X		No PA required	X	
96133	X			X		Must be used with 96132	X	
96136	X			X		Must be used with 96130 or 96132		
96137	X			X		Must be used with 96136		

Note: The "+" symbol identifies add-on codes that are performed in addition to the primary service or procedure code when medically necessary and must never be reported as stand-alone codes.

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.

Note: Please refer to State-Funded Policy: Telehealth and Virtual Communications for utilization and billing guidance on virtual patient communication codes (e.g., online digital E&M, telephonic E&M, and interprofessional consultation) billable by eligible psychiatric prescribers but which are not contained in this policy.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines. Documentation in the record must clearly indicate who provided the service.

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for services provided via telephonic, audio-only communication.

Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

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

a. Individuals under the Age of 21
Office, clinics, schools, homeless shelters, supervised living facilities, alternative family living facilities (AFL), home, and other community settings as clinically indicated.

b. Individuals Aged 18 and Over
Office, clinics, homeless shelters, assisted living facilities, supervised living facilities, alternative family living facilities (AFL), family care homes, adult care homes, home, and other community settings as clinically indicated.

Telehealth and telephonic claims should be filed with the provider's usual place of service code(s).

G. Co-payments

Not applicable.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, consult with the LME/MCO.

Note: State funds will not be utilized to reimburse for conversion therapy.

I. Coordination of Care

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