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Related Service Definition Policies

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

State-Funded Telehealth and Virtual Communication Services
State-Funded Enhanced Mental Health and Substance Abuse Services
State-Funded Assertive Community Treatment (ACT program)
State-Funded Community Support Team (CST)

1.0 Description of the Service

A diagnostic assessment is an intensive clinical and functional evaluation of an individual's mental health, intellectual and developmental disability, or substance use condition. A diagnostic assessment determines whether the individual meets medical necessity and can benefit from: mental health, intellectual disability, developmental disability, or substance use disorder services based on the individual's diagnosis, presenting problems, and treatment and recovery goals.

It evaluates the individual's level of readiness and motivation to engage in treatment. This assessment is designed to be delivered in a team approach that 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 written report must be kept in the service record.

Elements of the Diagnostic Assessment

A diagnostic assessment must include ALL 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 (including both mental health and substance use including 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's and legally responsible person's (if applicable) participation in the assessment;
f. analysis and interpretation of the assessment information with an appropriate case formulation including determination of American Society of Addiction Medicine (ASAM) level of care when a substance use disorder is present;
g. diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material including mental health, substance use disorders, or intellectual or developmental disabilities, as well as physical health conditions and functional impairment;

h. recommendations for additional assessments, services, supports or treatment based on the results of the diagnostic assessment;
i. the diagnostic assessment must be signed and dated by the licensed professionals completing the assessment; and
j. evidence of an interdisciplinary team service note that documents the team's review and discussion of the assessment. The involvement of the team in the delivery of the service is very important and is documented in the team note. Particular emphasis is made on the involvement and participation of all members of the team in the formulation of the diagnoses and treatment recommendations.

This assessment must be signed and dated by the MD, DO, PA, NP, or licensed psychologist and serves as the initial order for services included in the Person Centered Plan (PCP). Upon completion, the PCP shall be sent to the designated contractor for adminstratrive review and authorization of services.

1.1 Definitions

1.1.1 Diagnostic

Diagnostic means to examine specific symptoms and facts to understand or explain a condition.

1.1.2 Person Centered Plan (PCP)

A person-centered plan is the process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes.

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. Providers shall verify each individual's eligibility each time a service is rendered.

2.1.2 Specific

None apply.

3.0 When the Service Is Covered

3.1 General Criteria Covered

State funds shall cover the service related to this policy when 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.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

State funds shall cover Diagnostic Assessment when the following criteria are met:

a. there is a known or suspected mental health, substance use disorder, intellectual or developmental disability diagnosis based on the DSM-5 diagnostic criteria; or
b. initial assessment or triage information indicates a need for additional mental health, substance use disorder, intellectual, or developmental disabilities treatment or supports.

3.2.1.1 Continued Stay Criteria

Not applicable.

3.2.1.2 Discharge Criteria

Not applicable

3.2.2 State Funds Additional Criteria Covered

None apply.

3.3 Service Type and Setting

A diagnostic assessment is a direct periodic service that can be provided in any location. This service may be provided to the individual in-person or via telehealth.

4.0 When the Service Is Not Covered

4.1 General Criteria Not Covered

State funds shall not cover the service 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

State funds shall not cover a diagnostic assessment on the same day as Assertive Community Treatment Team, Intensive In-Home, Multisystemic Therapy or Community Support Team services. If psychological testing or specialized assessments are indicated, they are covered separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.

State funds and Community Mental Health Block Grant funds outside of UCR may be used to support an individual who is an inmate in a public correctional institution. Substance Abuse Prevention and Treatment Block Grant funds may not be used for this purpose.

State funds shall not cover conversion therapy.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State funds shall not require prior approval for the first event in a fiscal year of service. Additional events, in the same fiscal year, require prior authorization and utilization management from the designated contractor.

Note: A diagnostic assessment equals one event.

5.2 Prior Approval Requirements

5.2.1 General

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

a. the prior approval request; and

b. all health 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

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 eligible for this service.

5.3 Additional Limitations or Requirements

The Diagnostic Assessment report must document and include the elements described in **section 1.0.**

The Diagnostic Assessment team is responsible for completing all documentation on the diagnostic assessment for each individual being considered for services.

6.0 Provider(s) Eligible to Bill for the Service

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

a. meet LME-MCO qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for 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

The diagnostic assessment team shall include at least two Qualified Professionals (QPs), according to 10A NCAC 27G .0104:

a. For individuals with Mental Health (MH) or Substance Use Disorder (SUD) diagnoses, both professionals must be licensed. One team member shall be an MD, DO, nurse practitioner, physician assistant, or licensed psychologist. For substance use-focused diagnostic assessment, the team must include an LCAS.
b. For individuals with intellectual or developmental disabilities, one team member shall be an MD, DO, nurse practitioner, physician assistant, or licensed psychologist and one team member must be a master's level QP with at least two years of experience with individuals with intellectual or developmental disabilities.
c. The MD, DO, NP, PA, or psychologist shall have the required experience with the population served in order to provide this service.

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.)."

6.2 Provider Certifications

Diagnostic assessments must be conducted by practitioners employed by a mental health, substance abuse, or intellectual and developmental disability provider meeting the provider qualification policies, procedures, and standards established by Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division of MH/DD/SAS) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services.

Provider organizations must demonstrate that they meet these standards by being credentialed by the designated contractor. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be

established as a legally recognized entity in the United States and qualified or registered to do business as a corporate entity in the State of North Carolina.

A licensed clinician shall:

a. provide documentation verifying the completion of training on the current 2013 ASAM Criteria edition, or any subsequent editions of this reference material, consisting at a 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;

b. complete a Diagnostic Assessment that includes an ASAM level of care determination on an eligible individual diagnosed with a substance use disorder; **and**

c. Training must be a minimum of ten hours to ensure the above identified objectives are addressed. It is expected that clinician using the ASAM for Diagnostic Assessments completed on an individual with a substance use disorder seek out continuing education opportunities to maintain current knowledge of the ASAM criteria.

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

   All NC Division of MH/DD/SAS policies, guidelines, policies, provider manuals, implementation updates, and bulletins, DHHS, DHHS division(s) or fiscal contractor(s). Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with Federal law and regulations.

7.2 Expected Clinical Outcomes

Results from a diagnostic assessment include an appropriate case formulation, an interpretation of the assessment information including recommendations for services, supports, treatment or additional assessments; a service order for immediate needs; and the development of PCP. For an individual with a substance-use disorder diagnosis, a

diagnostic assessment must recommend the American Society of Addiction Medicine (ASAM) level of care determination.

8.0 Policy Implementation and History

Original Effective Date: January 1, 2004

History:

Date	Section or Subsection Amended	Change
11/01/2021	All Sections and Attachment(s)	Currently covered Diagnostic Assessment services are removed from the State-Funded Enhanced Mental Health and Substance Abuse Services, service definition package, to a new stand-alone service definition policy. ASAM criteria added as a requirement for individuals with SUD diagnosis.
2/15/2023	Section 1.1.2	Amended to change person centered to person-centered.
2/15/2023	Section 2.1.1	Added: b. Providers shall verify each individual's eligibility each time a service is rendered.
2/15/2023	Section 5.2.1	Amended "or utilization management contractor".
2/15/2023	Section 6.1	Added: "and Occupational Licensing Entity Regulations" to section title. Amended adding note below section that Licensed health professional employed by a tribal health program shall be exempt from licensing requirement of the State in which the tribal health program performs the services.
2/15/2023	Section 6.2	Amended adding ASAM level of care requirement for diagnostic assessment, ASAM training clarification with required learning objectives and minimum training hours.
2/15/2023	Section 7.1(b)	Amended adding wording stating that Federally recognized tribal and HIS providers may be exempt to one or more of these items in accordance with Federal law and Regulations.
2/15/2023	Section 7.2	Amended to correct spelling of diagnostic assessment and update wording.
2/15/2023	Attachment A, Section E	Amended adding wording stating that Federally recognized tribal or Indian Health Service providers may be entitled to alternate reimbursement methodologies under Federal Law and Regulations.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

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

C. Code(s)

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

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

HCPCS Code(s)
T1023

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Federally recognized tribal or Indian Health Service providers may be entitled to alternate reimbursement methodologies under Federal Law and Regulations.

If psychological testing or specialized assessments are indicated, they are billed separately using appropriate CPT codes for psychological, developmental, or neuropsychological testing.

F. Place of Service

Places of service vary depending on the specific service rendered. They include the following: community settings such as primary private residence, school, shelters, work locations, and hospital emergency rooms; licensed substance abuse settings; and licensed crisis settings.

A Diagnostic Assessment is a direct periodic service that can be provided in any location. *

*__Note:__ State funds and Community Mental Health Block Grant funds outside of UCR may be used to support an individual who is an inmate in a public correctional institution. Substance Abuse Prevention and Treatment Block Grant funds may not be used for this purpose.

G. Co-payments

N/A

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

A qualified provider who renders services to an individual shall bill all other third-party payers, including Medicaid and Medicare, before submitting a claim for state funded reimbursement.