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This service definition policy has an effective date of November 1, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by the Division of MH/DD/SAS through a series of Joint Communication Bulletins will remain in effect.

1.0 Description of the Service

Peer Support Services (PSS) are an evidenced-based mental health model of care that provides community-based recovery services directly to an adult diagnosed with a mental health or substance use disorder. PSS provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of individuals. PSS services are directly provided by Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS can be provided in combination with other approved mental health or substance use services or as an independent service. Due to the high prevalence of individuals with co-occurring disorders (mental health, substance use or physical health disorders), it is a priority that integrated treatment be available to individuals to be served.

PSS are based on the belief that individuals diagnosed with serious mental health or substance use disorders can and do recover. The focus of the services is on the person, rather than the identified mental health or substance use disorder and emphasizes the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery. The services promote skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

Peer Support Services (PSS) are provided one-on-one to the individual or in a group setting. Providing one-on-one support builds on the relationship of mutuality between the individual and CPSS; supports the individual in accomplishing self-identified goals; and may further support the individual's engagement in treatment. Peer Support Services provided in a group setting allow the individual the opportunity to engage in structured services with others who share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources to assist the individual in his or her recovery. PSS are based on the individual's needs and coordinated within the context of the individual's Person-Centered Plan. Structured services provided by PSS include:

a. **Peer mentoring or coaching (one-on-one) -** to encourage, motivate, and support the individual moving forward in recovery. Assist individual with setting self-identified recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as finding housing, developing natural support system, finding new uses of spare time, and improving job skills. Assist with issues that arise in connection with collateral problems such as legal issues or co-existing physical or mental challenges.

b. **Recovery resource connecting** – connecting an individual to professional and nonprofessional services and resources available in the community that can assist an individual in meeting recovery goals.

c. **Skill building recovery groups** – structured skill development groups that focus on job skills, budgeting and managing credit, relapse prevention, and conflict resolution skills and support recovery.

d. **Building community** – assist an individual enhancing his or her social networks that promote and help sustain mental health and substance use disorder recovery. Organization of recovery-oriented services that provide a sense of acceptance and belonging to the community, promote learning of social skills and the opportunity to practice newly learned skills.

1.1 Definitions

a. **Recovery** – a process of change through which an individual improves their health and wellness, lives a self-directed life and strives to reach their full potential; to live, work, learn, and participate fully in their communities.

b. **Self-Determination** - the right of an individual to direct his or her own services, to make decisions concerning their health and well-being, and to have help to make decisions from whomever they choose.

c. **Self-Advocacy** – identifying and purposefully asking for what one needs.

d. **Health** – learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing.

e. **Community** – Developing and building upon relationships and social networks that provide support, friendship, love and hope.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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**.

2.1.2 Specific

State funds shall cover Peer Support Services for an eligible individual who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

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 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 service definition policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in the State-Funded Telehealth and Virtual Communications, at **https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions**.

3.1.2 Telephonic Services

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

Refer to subsection 3.2.5.1 for **Telephonic-Specific Criteria**; 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 Peer Support Services when ALL the following criteria are met:

a. The individual has a mental health or substance use diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference material, other than a sole diagnosis of intellectual and developmental disability;
b. The individual meets the Level of Care criteria for Locus Level 1 or the American Society of Addiction Medicine (ASAM) Level 1 criteria;
c. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards; and
d. The individual has documented identified needs, in at least ONE or more of the following areas (related to diagnosis):
    1. Acquisition of skills needed to manage symptoms and utilize community resources;
    2. Assistance needed to develop self-advocacy skills to achieve decreased dependency on the mental health system;
    3. Assistance and support needed to prepare for a successful work experience;
    4. Peer modeling needed to take increased responsibilities for his or her own recovery; or
    5. Peer supports needed to develop or maintain daily living skills.

3.2.2 Admission Criteria

A comprehensive clinical assessment (CCA), that demonstrates medical necessity must be completed by a licensed professional prior to the 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 used as part of the current CCA. Relevant clinical information must be obtained and documented in the individual's Person-Centered Plan (PCP).

3.2.3 Continued Stay Criteria

The individual meets criteria for continued stay if any ONE of the following applies:

a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame documented in the individual's PCP;
b. The individual continues to be at risk for relapse based on current clinical assessment, and history, or the tenuous nature of the functional gains; or
c. Continuation of service is supported by documentation of the individual's progress toward goals within the individual's PCP.

3.2.4 Transition and Discharge Criteria

The individual meets the criteria for discharge if any ONE of the following applies:

a. The individual's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
b. The individual has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Peer Support Services;
c. The individual is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or
d. The individual chooses to withdraw from Peer Support Services or the legally responsible person(s) chooses to withdraw the individual from services.

For individuals receiving state funded services who are new to the enhanced MH/DD/SAS service delivery system, a completed LME-MCO Consumer Admission and Discharge Form must be submitted to the LME-MCO.

3.2.5 State-Funded Additional Criteria Covered

3.2.5.1 Telephonic-Specific Criteria:

a. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
b. Providers shall consider an individual's behavioral, physical and cognitive abilities to participate in services provided using telephonic, audio-only communication;
c. The individual's safety must be carefully considered for the complexity of the services provided;
d. 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 should also be considered;
e. Delivery of services using telephonic, audio-only communication must conform to professional standards of care including but not limited to ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and Licensing Board rules;
f. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;
g. Providers shall verify the individual's identity using two points of identification before initiating a telephonic, audio-only encounter; and,
h. Providers shall ensure that the individual's privacy and confidentiality is protected.

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 the following activities of Peer Support Services:

a. Transportation for the individual or family members;
b. Habilitation activities;
c. Time spent performing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of the Peer Support Specialist which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;

f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified in the individual's Person-Centered Plan;
i. Services provided without prior authorization;
j. Services provided to children, spouse, parents or siblings of the individual under treatment or others in the individual's life to address problems not directly related to the individual's needs and not listed on the Person-Centered Plan; and
k. Payment for room and board.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State-Funded PSS shall require prior approval for Peer Support Services beyond the unmanaged unit limitation. Coverage of Peer Support Services is limited to twenty-four (24) unmanaged units once per episode of care per state fiscal year. Refer to **Subsection 5.3** for additional limitations.

A service order must be signed prior to or on the first day PSS are rendered. Refer to **Subsection 5.4** of this policy.

LME-MCOs can offer less restrictive limitations on unmanaged units but cannot impose more restrictive limitations than the State-Funded Policy. All units beyond state-funded limitations or limitations imposed by the LME-MCO require prior approval.

LME-MCOs that offer less restrictive limitations on unmanaged units than that of the state-funded policy shall provide assurance that there are mechanisms in place to prevent over-billing for services.

Providers shall seek prior approval if they are uncertain that the individual has reached the unmanaged unit limit for the fiscal year.

Providers shall seek prior approval if the individual is engaged in other behavioral health or substance use services. Providers shall collaborate with the individual's existing provider to develop an integrated plan of care.

Prior authorization is not a guarantee of claim payment.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the LME-MCO the following:
a. the prior approval request (if unmanaged visits have been exhausted); 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 eligible individual.

Initial Authorization

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 Person-Centered Plan (PCP). Medical necessity is determined by North Carolina community practice standards, as verified by the LME-MCO 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 efficacious 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 treatment.

To request an initial authorization, the CCA, service order for medical necessity, PCP, and the required LME-MCO authorization request form must be submitted to the LME-MCO. State funds may cover up to 270 units of service (individual and group) for 90 days for the initial authorization period, if medically necessary. Refer to **Subsection 5.4** for Service Order requirements.

Reauthorization

Reauthorization requests must be submitted to the LME-MCO 10-days prior to the end date of the individual's active authorization. State funds may cover up to 270 units of service (individual and group) for 90 days for subsequent reauthorization periods, if medically necessary. Reauthorization is based on medical necessity documented in the PCP, the authorization request form, and supporting documentation. The duration and frequency at which PSS is provided must be based on medical necessity and progress made by the individual toward goals outlined in the PCP.

Additional units may be authorized as clinically appropriate. If medical necessity dictates the need for increased service duration and frequency, clinical consideration must be given to interventions with a more intense clinical component.

Note: Any denial, reduction, suspension, or termination of service requires notification to the individual, legally responsible person or both about the individual's appeal rights pursuant to G.S. 43B-147(a)(9) and Rules10A NCAC27I .0601-.0609.

5.3 Additional Limitations or Requirements

a. An individual can receive PSS from only one provider organization during an active authorization period. The individual may choose a new provider at any time, which will initiate a new service authorization request and a new authorization period.

b. Family members or legally responsible person(s) of the individual are not eligible to provide this service to the individual receiving the service.
c. An individual with a sole diagnosis of Intellectual/Developmental Disabilities is not eligible for PSS funded by state funds.
d. Peer Support must not be provided during the same authorization period as Assertive Community Treatment Team (ACTT), as a peer support specialist is a requirement of that team.
e. Peer Support must not be provided during the same authorization period as Community Support Team (CST), as a peer support specialist may be a component of the service and an individual who is in need of CST and peer support will be offered CST providers who have peers on the team.
f. PSS must not be provided during the same time of day when an individual is receiving Substance Abuse Intensive Outpatient Program (SAIOP) or Substance Abuse Comprehensive Outpatient Treatment (SACOT), Partial Hospitalization, Psychosocial Rehabilitation, Respite, or Individual Support services.
g. PSS must not be duplicative of other state-funded services the individual is receiving.
h. Transportation of an individual receiving state funded PSS is not covered as a component for this policy. Any provision of services provided to an individual during travel must be indicated in the PCP prior to the travel and must have corresponding documentation supporting intervention provided.

Note: PSS is not a "first responder" service. As documented in the individual's PCP Comprehensive Prevention and Intervention Crisis Plan, the PSS provider shall coordinate with other service providers to ensure "first responder" coverage and crisis response.

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the individual's needs. A service order must be signed by a physician or other licensed clinician per his or her scope of practice, prior to or on the first day service is rendered.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
c. A service order must be in place prior to or on the first day that the service is initially provided to bill state funds for the service; and

d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP service order.

5.5 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. To bill state funds, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by state funds. The staff person who provides the service shall sign and date the written entry. The signature must include credentials for the staff member who provided the service. The PCP and a documented discharge plan must be discussed with the individual and documented in the service record.

5.5.1 Contents of a Service Note

For this service, a full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must document ALL following elements:

a. Individual's name;
b. Service record identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (in person, telehealth or telephonic, audio-only communication);
f. Place of service;
g. Purpose of contact as it relates to the PCP goals;
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, start and end time of intervention; total amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

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

Peer Support Services must be delivered by practitioners employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Division of MH/DD/SAS;
b. meet the requirements of 10A NCAC 27G;
c. demonstrate that they meet these standards by being credentialed and contracted by an LME-MCO;
d. within one calendar year of enrollment as a provider with the LME-MCO, achieve national accreditation with at least one of the designated accrediting agencies; and
e. become established as a legally constituted entity capable of meeting all the requirements of the DMH/DD/SAS Bulletins and service implementation standards.

6.2 Provider Certifications

PSS must be provided by a Peer Support Specialist certified by North Carolina's Peer Support Specialist Program.

6.2.1 Staff Requirements

The Peer Support Services (PSS) program is provided by qualified providers with the capacity and adequate workforce to offer this service to individuals meeting a state-funded Benefit Plan. PSS must be available during times that meet the needs of the individual which may include evening, weekends, or both. The PSS program must be under the direction of a full-time Qualified Professional (QP) who meets the requirements according to 10A NCAC 27G .0104 (19).

The PSS program must have designated competent mental health or substance use professionals to provide supervision to CPSS during the times of service provision.

The maximum program staff ratios are as follows: QP-to-CPSS is 1:8; CPSS-to individual is 1:15; and group ratio for CPSS Group Facilitator-to-Individuals is 1:12.

The PSS program must follow the NC Peer Support Specialist Code of Ethics and Values and principles when rendering PSS services. All ethical issues must be governed by the administrators of the Peer Support Specialist Registry and policies and procedures established by the hiring provider agency.

CPSS shall not work outside the scope of their certification or core competencies. CPSS shall only provide services to an individual with similar lived experiences.

The following charts provide required services of the PSS Program Supervisor and core competencies of relationship building and peer support interaction for the CPSS (according to NC's Certified Peer Support Specialist Program).

Peer Support Services Program Supervisor
• Trained in quality supervisory skills. • Possess knowledge of the CPSS role and work, as well as, understand the principles and philosophy of recovery and the code of ethics of the NC Peer Support Specialist Certification Program. • Understand and support the role of the CPSS. • Understand and promote the individual's recovery. • Advocate for the CPSS and PSS across the organization and in the community. • Promote both the professional and personal growth of the CPSS within established human resource standards. • Coordinate assessments needed for the individual. If appropriately licensed, the QP may conduct the assessments. • Collaborate with individual(s) and CPSS to develop recovery-oriented person-centered plan(s) for the individual that demonstrates consideration for integrated care. • Conduct at least one <u>in-person, telehealth, or</u> telephonic, audio-only communication contact with the individual within 90 days of PSS being initiated and no less that every 90 days thereafter to monitor the individual's progress and effectiveness of the program; and to review with the individual, the goals of their PCP and document progress. • Plan work assignments, monitors, reviews and evaluates work performance of program staff and facilitates staff meetings and conduct routine reviews of service notes for quality assurance. • Provide administrative and supportive supervision to program staff individually at least once per month or more if needed. Provision of supervision must be based on the experience of the individual staff. • Collaborate with program staff to assess strengths and areas of growth and develop an individual supervision plan. • Collaborate and foster collegial roles with program staff. • Determine team caseload size based on the level of acuity and needs of the individual(s). • Facilitate or co-facilitate skill building recovery groups based on the needs or request of individuals. • Ensure referrals for community resources requested by the individual(s) are completed.

Certified Peer Support Specialist
• Knowledge of peer support principles, values and ethics. • Ability to share lived experience to support, encourage and enhance an individual's treatment and recovery. • Possess recovery-oriented skills and knowledge to provide peer support services.

- Ability to collaborate with the program QP to assess their own strengths and areas of growth and develop a supervision plan.
- Ability to collaborate with an individual to explore and identify barriers to accessing community resources or treatment providers.
- Ability to model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for individuals served and to promote a recovery environment in the community, residence, and workplace.
- Ability to explore with an individual served, the importance and creation of a wellness identity through open sharing and challenging viewpoints.
- Ability to promote an individual's opportunity for personal growth by identifying teachable moments for building relationship skills to empower the individual and enhance personal responsibility.
- Ability to model and share decisions-making tools to enhance an individual's healthy decision-making process.
- Ability to provide examples of healthy social interactions and facilitate familiarity with, and connection to, the local community.
- Ability to recognize and appropriately respond to conditions that constitute an emergency to include both physical and behavioral health crisis utilizing the emergency response procedure of employer.
- Ability to provide support to the individual in navigating systems (medical, social services, or legal).
- Ability to promote self-advocacy by facilitating each individual's learning about his or her human and legal rights and supporting the individual while exercising those rights to support the empowerment of the individual.

6.2.2 Training Requirements

To provide effective peer support services, all PSS program staff shall possess the knowledge and competencies of peer support principles, values and ethics and participate in additional trainings required to provide the service. Required trainings for PSS program staff are as follows:

Timeframe	Training Required	Who	Total Minimum Hours Required
Within **30 calendar days** of hire to provide service	• 3 hours of Peer Support Services Policy components review • 1 hour of Documentation Training	• All staff	4 hours

Within **90 calendar days** of hire to provide service	• 3 hours of Peer Support Supervisor Training • 12 hours of Person-Centered Thinking • 3 hours of PCP Instructional Elements with Comprehensive Prevention and Intervention Crisis Plan Training	• Peer Support Services Program Supervisor	18 hours
Annually	• Continuing education	• All staff	10 hours

Peer support program staff shall complete initial requirements of training identified above within identified timeframes. The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training was completed no more than 24-months prior to hire date.

Peer support program staff shall participate in additional hours of peer support related training that is appropriate for the population being served. Additional training options for all PSS program staff include:

a. Trauma Informed Care
b. Wellness and Recovery Action Plan (WRAP)
c. Whole Health Action Management (WHAM)
d. Basic Mental Health and Substance Use 101
e. Mental Health First Aid
f. Housing First, Permanent Supportive Housing, Tenancy Support Training

6.3 Expected Outcomes

The expected outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the individual's PCP.

Expected outcomes:

a. increased engagement in self-directed recovery process;
b. increased natural and social support networks;
c. increased ability to engage in community activities;
d. increased ability to live as independently as possible and use recovery skills to maintain a stable living arrangement;
e. higher levels of empowerment and hopefulness in recovery;
f. improved emotional, behavioral and physical health;
g. improved quality of life;
h. improved vocational skills;
i. decreased substance use;
j. decreased frequency or intensity of crisis episodes; or
k. decreased use of crisis services or hospitalizations.

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 NC Division of MH/DD/SAS's service definitions, guidelines, policies, provider manuals, implementation updates, and bulletins, DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: August 1, 2019 **History:**

Date	Section or Subsection Amended	Change
8/1/19	All Sections and Attachment(s)	New policy implementing Peer Support Services.
11/1/19	5.3 Additional Limitations or Requirements	5.3 d. & e. Clarification regarding PSS during ACT and CST authorizations; 5.3 f. Inclusion of PSR, respite and individual support services;
11/1/19	5.4 Service Orders	Revised language to include signature by a physician or other licensed clinician per his or her scope of practice prior to or on the first day service is rendered.
11/1/19	6.2.1 Staff Requirements	Provided clarification regarding PSS availability; Code of Ethics requirements and PSS supervision. Added requirement to PSS Supervisor responsibility to conduct routine reviews of service notes for quality assurance.
11/1/19	Attachment A: Claims-Related Information F.	Added emergency department as a place of service.
12/15/19	Attachment A	Added Note: The Division of MH/DD/SAS will not reimburse for conversion therapy.
11/1/21	Related Service Definition Policies	State-Funded Telehealth and Virtual Communications
	Subsection 3.1.1	Added new subsection 3.1.1 Telehealth Services.
	Subsection 3.1.2	Added new subsection 3.1.2 Telephonic Services
	Subsection 3.2.5.1	Added new subsection 3.2.5.1 Telephonic Specific-Criteria

	Subsection 5.5.1	Updated policy language. Deleted: "face-to face, phone". Added: "in person, telehealth or telephonic, audio-only communication".
	Subsection 6.2.1	Updated policy language. Deleted: "face-to-face" and "telephone". Added: "in-person, telehealth or telephonic, audio-only communication".
	Attachment A, letter C	Added columns to service codes indicating if the services were eligible for telehealth and telephonic, audio-only communication. Added "Note: Telehealth and telephonic, audio-only communication eligible services may be provided to both new and established individuals by the eligible providers listed within this policy."
	Attachment A, Letter D	Added the following language for telehealth services: 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.
	Attachment A, Letter F	Deleted: "telephone" and "face-to-face". Added: "telehealth or telephonic, audio-only" and "in-person". Added language: Telehealth and telephonic, audio-only communication claims should be filed with the provider's usual place of service code(s).
	Added beginning of Policy	Added the language: This service definition policy has an effective date of November 1, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by the Division of MH/DD/SAS through a series of Joint Communication Bulletins will remain in effect.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (837P transaction)

Institutional (837I 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 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 service using the appropriate unlisted service code.

HCPCS Code(s)	Billing Unit	Telehealth Eligible	Telephonic Eligible
H0038	1 unit = 15 minutes	Yes	Yes
H0038 HQ	1 unit = 15 minutes	No	No

Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

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.

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 code(s) used which determines the billing unit(s).

Units are billed in 15-minute increments.

LME-MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME-MCOs shall assess their PSS network providers' adherence to service guidelines to assure quality services for individuals served.

F. Place of Service

PSS is a direct periodic service provided in a range of community settings. It may be provided in the individual's place of residence, community, in an emergency department or in an office setting. It may not be provided in the residence of PSS staff.

The intent of the service is to be community-based rather than office-based. Service may be provided via telehealth or telephonic, audio-only communication. Telehealth or telephonic, audio-only communication time is supplemental rather than a replacement of in-person contact and is limited to twenty (20) percent or less of total service time provided per individual per fiscal year. Documentation of service rendered via telehealth or telephonic, audio-only communication with the individual or collateral contacts (assisting individual with rehabilitation goals) must be documented according to Subsection **5.5** of this policy.

Telehealth and telephonic, audio-only communication 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.

Note: The Division of MH/DD/SAS will not reimburse for conversion therapy.