**Division of Medical Assistance**
**Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers**

**Clinical Coverage Policy No. 8C**
**Original Effective Date: January 1, 2005**
**Revised Date: June 1, 2007**

# Table of Contents

# 1.0 Description of the Service

Outpatient behavioral health services include assessment, treatment (individual medical evaluation and management, including medication management, individual and group therapy, behavioral health counseling), family therapy, and psychological testing for recipients of all ages.

# 2.0 Eligible Recipients

All Medicaid-eligible recipients are eligible for services.

## 2.1 General Provisions

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

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

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

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

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

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

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

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

## 3.0 When the Service Is Covered

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

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 3.1 General Criteria

Medicaid covers services when they are medically necessary and

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

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

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

## 4.0 When the Service Is Not Covered

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

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 4.1 General Criteria

Services are not covered when

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

### 4.2 Specific Criteria

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

Sleep therapy for psychiatric disorders is not covered.

## 5.0 Requirements for and Limitations on Coverage

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

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

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

### 5.1 Service Limitations

Medicaid does not reimburse for the same services provided by the same provider on the same day.

Only one psychiatric interview (CPT codes 90801, 90802) by the same provider is allowed in a 6-month period.

### 5.2 Referral

#### 5.2.1 Recipients under the Age of 21

Services provided to recipients under the age of 21 require a referral by a Carolina ACCESS primary care provider, the local management entity or a Medicaid-enrolled psychiatrist.

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

#### 5.2.2 Recipients Aged 21 and Over

Services provided to recipients age 21 or over may be self-referred or referred by some other source.

### 5.3 Prior Approval

#### 5.3.1 Recipients under the Age of 21

Coverage is limited to 26 unmanaged outpatient visits per calendar year. Visits beyond 26 per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant and prior approval from the utilization review contractor. To ensure timely prior authorization, requests should be submitted prior to the 26th visit.

#### 5.3.2 Recipients Aged 21 and Over

Coverage is limited to 8 unmanaged outpatient visits per calendar year. Visits beyond 8 per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant, and prior approval from the utilization review contractor.

#### 5.3.3 Medicare Qualified Beneficiaries

Prior authorization is not required for the MQB eligibility category.

### 5.4 Place of Service

#### 5.4.1 Recipients under the Age of 21

Place of service is limited to the provider's office, clinic, school, residential facilities, and home.

#### 5.4.2 Recipients Aged 21 and Over

Place of service is limited to the provider's office, clinics, home, nursing facilities, assisted living facilities, and adult care homes.

## 6.0 Providers Eligible to Bill for the Service

In addition to physicians the following providers may bill for these services:

a. licensed psychologists (doctorate level)
b. licensed psychological associates (LPA)
c. licensed professional counselors (LPC)
d. licensed marriage and family therapists (LMFT)
e. licensed clinical social workers (LCSW) with a masters degree in social work from a school of social work accredited by the Council of Social Work Education
f. nurse practitioners approved to practice in North Carolina and certified by the American Nurses Credentialing Center as an advanced practice nurse practitioner and certified in psychiatric nursing

**or**

**Note:** The Division of Medical Assistance (DMA) shall extend to nurse practitioners who are certified in another specialty with two years of documented mental health experience. These nurse practitioners will be enrolled under a sunset clause that will require psychiatric certification at the end of a five-year period. **IF** this certification is not obtained by June 30, 2010, enrollment will be terminated.

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

h. certified clinical supervisors (CCS)

i. licensed clinical addictions specialists (LCAS)

Providers may enroll as individuals or as a single-specialty or multi-specialty group.

# 7.0 Additional Requirements

## 7.1 Consent

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

## 7.2 Coordination of Care

The provider is responsible for the coordination of care activities, which may include but are not limited to the following:

a. Written progress or summary reports

b. Telephone communication

c. Treatment planning processes

d. Other activities jointly determined by the referring provider and the behavioral health provider to be necessary for the continuity of care

## 7.3 Documentation

### 7.3.1 Provision of Services

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

a. The recipient's name and date of birth on each page

b. A description of services performed and dates of service

c. The client response to therapy

d. The duration of service (length of assessment or treatment in minutes)

e. The signature of the person providing the service

f. A copy of any testing or summary and evaluation reports

g. Documentation of communication regarding coordination of care activities

### 7.3.2 Recipients under the Age of 21

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

a. a referral from a Carolina ACCESS primary care provider, Medicaid-enrolled psychiatrist or local management entity, and

b. a copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 26$^{th}$ visit

c. a copy of the completed authorization form and prior approval notification from the utilization review contractor for visits 27 and beyond.

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

#### 7.3.3 Recipients Aged 21 and Over

For recipients age 21 and over, documentation must include

a. a copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 8th visit

b. a copy of the completed authorization form and prior approval notification from the utilization review contractor for visits 9 and beyond.

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

### 7.4 Service Access

Enrolled providers must provide or have written agreement with another entity for access to 24-hour coverage for emergency services.

## 8.0 Billing Guidelines

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

### 8.1 Claim Type

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

### 8.2 Diagnosis Codes That Support Medical Necessity

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

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

a. Medicaid covers six unmanaged visits without a diagnosis of mental illness or substance abuse.

b. The first two visits can be coded with ICD-9-CM code 799.9 (a nonspecific code) and the following four visits can be coded with "V" diagnosis codes.

OR

a. The first visit can be coded with diagnosis 799.9 and the remaining five can be coded with "V" diagnosis codes.

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

c. Visits seven and beyond require an ICD-9-CM code between 290 and 319.

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

### 8.3 Procedure Codes

Physicians bill appropriate CPT codes which may include Evaluation and Management (E/M) codes. E/M codes are not specific to mental health and are not subject to prior approval. However, these codes are subject to the 24 visit per year limit for adults. For recipients under the age of 21 there is no limit to E/M codes allowed per year.

Behavioral health–specific codes are billable by physicians according to the services they render and would be subject to prior approval if utilized. Other providers bill specific codes as indicated below.

| Professional Specialty | Related Codes |
|---|---|
| Licensed Psychologist | 96101, 96110, 96111, 96116, 96118, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849,90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Licensed Psychological Associate | 96101, 96110, 96111, 96116, 96118, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Licensed Clinical Social Worker | 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0004, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Licensed Professional Counselor | 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Licensed Marriage and Family Counselor | 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |

| Professional Specialty | Related Codes |
|---|---|
| Certified Nurse Practitioner | 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90862, 90805, 90807, 90809, 90811, 90813, 90815<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Certified Clinical Nurse Specialist | 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Licensed Clinical Addictions Specialist | 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857<br>90816, 90818, 90821, 90823, 90826, 90828 in residential facilities<br>H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |
| Certified Clinical Supervisor | H0031, H0001, H0005<br>H0004 (with or without one of the following modifiers, as appropriate: HQ, HR, or HS) |

## 8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

Payment is made according to the specialty of the provider delivering the service, whether practicing independently or employed by physicians or clinics.

# 9.0 Policy Implementation/Revision Information

**Effective Date:** January 1, 2005

**Revision Information:** September 1, 2006

| Date | Section Revised | Change |
|---|---|---|
| 5/1/05 | 6.0 | The requirements for nurse practitioners were revised to include a sunset clause that allows a five-year period for nurse practitioners who are certified in another specialty with two years of documented mental health experience a to obtain psychiatric certification. |
| 9/1/05 | Section 2.0 | A special provision related to EPSDT was added. |
| 11/1/05 | Section 7.3.1 | The requirement to list the recipient's name and Medicaid identification number on each page of the medical record was revised; providers are required to list the recipient's name and date of birth on each page of the medical record. |
| 12/1/05 | Section 2.2 | The Web address for DMA's EDPST policy instructions was added to this section. |
| 1/1/06 | Section 8.3 | CPT code 96100 was end-dated and replace with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118. |
| 9/1/06 | Sections 6.0 and 8.3 | Changed "certified" to "licensed" and abbreviations from CCS and CCAS to LCS and LCAS. |
| 12/1/06 | Section 2.2 | The special provision related to EPSDT was revised. |
| 12/1/06 | Sections 3.0, 4.0, and 5.0 | A note regarding EPSDT was added to these sections. |
| 5/1/07 | Section 8.3 | Services provided by licensed clinical addictions specialists and certified clinical supervisors were expanded to include psychiatric and psychotherapeutic procedure codes. CPT code 90809 was added to the certified nurse practitioner block. |
| 5/1/07 | Sections 2 through 5 | EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age. |
| 6/1/07 | Sections 6.0, 8.3 | Updated the title of Licensed Clinical Supervisor to Certified Clinical Supervisor; deleted CPT codes from list of codes a Certified Clinical Supervisor may bill. |
| 6/1/07 | Sections 3 and 4 | Added standard statements of coverage conditions. |

| Date | Section Revised | Change |
|---|---|---|
| 6/1/07 | Section 5.3.3 | Created separate category for MQB recipients. |
| 6/1/07 | Section 8.2 | Added "substance abuse" to the first list item lettered "a." |
| 6/1/07 | Section 8.3, 2nd paragraph | Changed "mental health specific codes" to "behavioral health–specific codes." |